

Prison Rape Elimination Act (PREA) Audit Report Juvenile Facilities

☐ Interim ☒ Final

Date of Report February 26, 2019

Auditor Information

Name: Emily Childs	Email: emily.childs@tjtd.texas.gov
Company Name: Click or tap here to enter text.	
Mailing Address: 11209 Metric Blvd, Bldg H, Ste A	City, State, Zip: Austin TX, 78758
Telephone: (512)490-7968	Date of Facility Visit: June 20-21, 2018

Agency Information

Name of Agency Texas Juvenile Justice Department		Governing Authority or Parent Agency (If Applicable) Click or tap here to enter text.	
Physical Address: 11209 Metric Blvd, Bldg H, Ste A		City, State, Zip: Austin TX 78758	
Mailing Address:		City, State, Zip: Click or tap here to enter text.	
Telephone: (512) 490-7130		Is Agency accredited by any organization? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
The Agency Is:	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input checked="" type="checkbox"/> State	<input type="checkbox"/> Federal
Agency mission: Transforming young lives and creating safer communities.			
Agency Website with PREA Information: www.tjtd.texas.gov			

Agency Chief Executive Officer

Name: Camille Cain	Title: Executive Director
Email: Camille.cain@tjtd.texas.gov	Telephone: (512)490-7130

Agency-Wide PREA Coordinator

Name: Carla Bennett-Wells	Title: PREA Coordinator
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Email: Carla.Bennett.Wells@tjjd.texas.gov		Telephone: (254)297-8273	
PREA Coordinator Reports to: Director of Monitoring and Inspections		Number of Compliance Managers who report to the PREA Coordinator 13	
Facility Information			
Name of Facility: Ayres Halfway House			
Physical Address: 17259 Nacogdoches Rd, San Antonio TX 78266			
Mailing Address (if different than above): Click or tap here to enter text.			
Telephone Number: (210) 651-4374			
The Facility Is:	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input checked="" type="checkbox"/> State	<input type="checkbox"/> Federal
Facility Type:	<input type="checkbox"/> Detention	<input type="checkbox"/> Correction	<input type="checkbox"/> Intake <input checked="" type="checkbox"/> Other
Facility Mission: The mission of Texas Juvenile Justice Department (TJJD) halfway houses is to ensure public protection by providing TJJD youth with community-based services that:(1) emphasize positive development, discipline training, and accountability;(2) retrain youth to become productive and responsible citizens through education, vocational training, and work opportunities with intensive family and community collaboration; and(3) rehabilitate and reestablish youth in society through a competency-based program founded on evidence-based practices and measurable outcomes.			
Facility Website with PREA Information: www.tjjd.texas.gov			
Is this facility accredited by any other organization? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Facility Administrator/Superintendent			
Name: Byron Mueller		Title: Superintendent	
Email: Byron.mueller@tjjd.texas.gov		Telephone: (210)651-4374	
Facility PREA Compliance Manager			
Name: Frederick Wilson		Title: Assistant Superintendent	
Email: Frederick.wilson@tjjd.texas.gov		Telephone: (210)651-4374	
Facility Health Service Administrator			
Name: Amber Laake		Title: RN	
Email: amlaake@utmb.edu		Telephone: (979)542-4552	

Facility Characteristics		
Designated Facility Capacity: 24		Current Population of Facility: 18
Number of residents admitted to facility during the past 12 months		107
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:		107
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:		107
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:		0
Age Range of Population:	14-19	
Average length of stay or time under supervision:		2 months
Facility Security Level:		Medium
Resident Custody Levels:		Low to Medium
Number of staff currently employed by the facility who may have contact with residents:		21
Number of staff hired by the facility during the past 12 months who may have contact with residents:		21
Number of contracts in the past 12 months for services with contractors who may have contact with residents:		2
Physical Plant		
Number of Buildings: 1		Number of Single Cell Housing Units: 0
Number of Multiple Occupancy Cell Housing Units:		0
Number of Open Bay/Dorm Housing Units:		6
Number of Segregation Cells (Administrative and Disciplinary):		0
<p>Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):</p> <p>Ayres House is equipped with more than 50 surveillance cameras throughout the facility and outside to augment the staff's supervision and monitoring of the youth. There is no central control room, but staff can view the cameras on multiple computers throughout the facility. Video is retained for 90 days.</p>		
Medical		
Type of Medical Facility:		Hospital
Forensic sexual assault medical exams are conducted at:		Methodist Children's Hospital, San Antonio TX
Other		
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:		25
Number of investigators the agency currently employs to investigate allegations of sexual abuse:		19

Audit Findings

Audit Narrative

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

Introduction

The Prison Rape Elimination Act (PREA) on-site audit of the Ayres Halfway House (Ayres House) in San Antonio, Texas was conducted from June 20-21, 2018. Ayres House is one of seven halfway houses and six secure facilities operated by the Texas Juvenile Justice Department. Ayres House has had one previous PREA audit, dated April 28, 2015. The final audit report found that the facility met all applicable standards, after completing corrective actions for §115.313, §115.341, §115.353. The specific corrective actions are detailed in the standard specific discussions within this report.

The members of the audit team were certified PREA auditors consisting of Emily Childs, Lisa Hale and Allen Hall. Emily Childs served as the lead auditor. The members of the audit team are employees of the Independent Ombudsman for the Texas Juvenile Justice Department (OIO), which is a state agency, with the agency head (Chief Ombudsman) reporting directly to the Governor of Texas. A memorandum of understanding (MOU) between the Chief Ombudsman and the Executive Director of the Texas Juvenile Justice Department (TJJD) was fully executed on May 21, 2018, with an effective date of June 1, 2018. The MOU states that the OIO will "conduct audits of TJJD-operated facilities in accordance with PREA and all related statutes, rules, and regulations." No barriers were encountered that hindered the completion of this audit.

Pre-On site Audit Phase

On May 3, 2018, in anticipation of the completion of the MOU, the Deputy Chief Ombudsman emailed TJJD's Interim PREA Coordinator to arrange the dates of the audits to be conducted for TJJD during the current audit cycle. June 20-21, 2018 were agreed upon by both parties as the dates of the on-site portion of the Ayres House PREA audit. On May 4, 2018, Emily Childs emailed the Interim PREA Coordinator, the facility PREA Compliance Manager, and the facility Superintendent the written instructions for posting audit notices along with both English and Spanish versions of the audit notices. Ms. Childs requested the notices be posted by Tuesday, May 8, 2018, to ensure they were posted at least 6 weeks prior to the on-site audit. She requested that the Compliance Manager provide confirmation that the notices were posted and send photos of posted notices, including a description of the locations, by the close of business on May 8, 2018. The Compliance Manager responded to Ms. Childs on May 7, 2018, by emailing 15 pictures of notices posted throughout the facility. The notices were printed with large text on brightly colored green and yellow paper. They listed the dates and purpose of the PREA audit and provided contact information for the lead auditor. The notices informed the residents that any letters they send may not be opened by facility staff and anything sent will be kept confidential and can only be disclosed if required by law. The supplied pictures were taken in the administration hallway, classroom, conference room, day room, dining room, kitchen, medical room, reception area, and seven offices throughout the halfway house.

On May 17, 2018, an introductory telephone call was conducted with Emily Childs and Lisa Hale from the audit team, the agency PREA Coordinator, and the PREA Compliance Manager of the facility. During this call, the participants discussed the audit process and purpose, the audit goals and expectations, the purpose of corrective action, and the logistics of the audit. Emily Childs was identified as the sole party responsible for communications from the audit team. The PREA Compliance Manager was identified as the responsible party for the facility, with correspondence to also be copied to the PREA Coordinator. It was discussed that the audit team must have access to all areas of the facility and documentation related to sexual safety including medical, mental health, investigations, and human resources. The confidentiality of resident and staff correspondence was discussed, with the understanding that correspondence to the audit team would be treated like legal correspondence. A due date of June 4, 2018, was established for the facility to provide the Pre-Audit Questionnaire (PAQ) and all documentation to the audit team. Following the conclusion of the telephone call, on May 17, 2018, Emily Childs emailed the facility PREA Compliance Manager and the Interim PREA Coordinator the PREA Audit Process Map and the PREA Audit Checklist of Documentation.

The completed PAQ and supporting documentation were provided to the audit team on June 4, 2018. The audit team reviewed the provided materials and on June 12, 2018, Emily Childs emailed the Interim PREA Coordinator, facility PREA Compliance Manager, and facility Superintendent an issue log of items needing follow up. Information regarding the number of sexual abuse and sexual harassment allegations was provided in the PAQ and additional information regarding the total number of allegations; number determined to be substantiated, unsubstantiated, or unfounded; number of cases in progress; number of criminal investigations; and number of administrative investigations was also requested in the issue log.

On June 14, 2018, Ms. Childs emailed the Interim PREA Coordinator, facility PREA Compliance Manager, and facility Superintendent a document detailing rosters to be provided to the audit team prior to their arrival. The requested information included:

1. Complete resident roster
2. Residents with disabilities (i.e., physical disabilities, blind, deaf, hard of hearing, cognitive disabilities)
3. Residents who are Limited English Proficient (LEP)
4. Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Residents
5. Residents who reported sexual abuse
6. Residents who reported sexual victimization during risk screening
7. Complete staff roster
8. Specialized staff which includes:
 - Intermediate- or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment
 - Medical staff
 - Mental health staff
 - Non-Medical staff involved in cross-gender strip or visual searches
 - Administrative (human resources) staff
 - Volunteers who have contact with residents
 - Contractors who have contact with residents
 - Investigative staff
 - Staff who perform screening for risk of victimization and abusiveness
 - Staff on the sexual abuse incident review team
 - Designated staff member charged with monitoring retaliation

- First responders-both security and non-security staff
- Intake Staff

The Texas Juvenile Justice Department does not have youthful inmates or detainees. Additionally, Ayres House does not use segregated housing or isolation. (This was verified on-site through observation and resident and staff interviews.) Therefore, these rosters were not requested.

Additionally, lists of grievances, incident reports, and hotline calls were not requested, as the audit team was granted access to databases, created and maintained by TJJD, containing this information for Ayres House. This information was reviewed by the auditors prior to the on-site portion of the audit.

On June 18, 2018, Emily Childs received two emails, one from the facility PREA Compliance Manager and one from the PREA Coordinator, containing responses and additional documentation requested in the issue log.

External Contacts/Research

On June 5, 2018, Emily Childs made contact with Just Detention International (JDI) regarding information they may have about Ayres House. JDI conducted a search of their records and found no reports involving Ayres House. On June 12, 2018, Ms. Childs contacted The Rape Crisis Center, and spoke with a representative who confirmed they have an MOU with TJJD and they would provide crisis intervention services for Ayres House. She said they work with local hospitals and are called in when a youth is admitted to the hospital for a forensic medical exam. The representative said they have never received a call regarding a youth at Ayres House.

TJJD nursing staff was contacted and the lead auditor was told that residents would be taken to Methodist Children's Hospital for a SAFE/SANE exam. Ms. Childs contacted Methodist Children's Hospital and was transferred to the Methodist Specialty and Transplant Hospital, within the same hospital system. She spoke with a representative who said that if a victim was brought to Methodist Children's Hospital, they would be taken down the street to Methodist Specialty and Transplant Hospital, which is a part of the same family of hospitals. She confirmed that Methodist Specialty and Transplant Hospital has a SANE nurse available 24 hours a day. The hospital works with organizations, including The Rape Crisis Center, who provide crisis intervention services.

An internet search was conducted for information regarding Ayres House. Only one recent news article was found. This article discussed a non-profit organization that donated books to the halfway house. There was no information regarding any litigation or federal or state oversight issues. TJJD's website was reviewed for information regarding PREA. The website contains an introductory discussion of PREA, links to Texas laws related to prosecution of PREA related incidents, and frequently asked questions with answers. The website contains links to national PREA resources and TJJD PREA related publications. The agency has also posted final PREA reports of TJJD facilities and the agency Annual PREA Reports.

The auditor viewed the Texas Family Code Section 261.101 to determine mandatory reporting laws. Texas law requires that anyone who suspects child abuse or neglect report it immediately. Therefore, the members of the audit team are mandatory reporters. The Texas Juvenile Justice Department does not have youthful inmates or detainees, so the process to certify juveniles as adults in Texas was not researched.

Ms. Childs received no confidential correspondence from residents of Ayres House prior to the on-site audit.

On-site Audit Phase

Site Review

The audit team arrived on site at Ayres House on June 20, 2018. An entrance briefing was conducted with the audit team and the Interim PREA Coordinator, facility PREA Compliance Manager (who is also the Assistant Superintendent), and the Superintendent. The audit team was provided an empty classroom to serve as a base of operations and to conduct interviews. A conference room and an office were also provided for the auditors to conduct interviews.

On the first day of the audit, the auditors conducted a site review of the facility. The Assistant Superintendent guided the audit team throughout the facility. Ayres House is contained in a single building and can house up to 24 residents. There are four bedrooms, with each room able to accommodate four residents. On the first day of the audit, the facility had 18 male residents. During the site review, all areas of the facility were reviewed. The auditors observed all areas of the facility, including the classroom, dayroom, all six bedrooms, the kitchen area, conference room, bathrooms, and offices. The outer perimeter of the building was observed along with two storage sheds. Camera placement was observed, with only one potential blind spot noted. The blind spot was discussed with the Assistant Superintendent who noted that nearby cameras capture the surrounding area and would record individuals entering that area. To completely cover the blind spot, a new camera would have to be installed in this location. The auditors did not observe any camera placements that would create privacy concerns. There are no cameras in the residents' restrooms. During informal and random interviews with staff and residents, it was stated that residents shower, change, and use the restroom in the restroom areas.

Ayres House does not have designated intake, screening, or classification areas. These processes occur in a staff member's office. There is no separate file storage area. The auditors were shown a locked file cabinet in one of the offices where some resident information is stored. All current residents had completed the inmate education process prior to the auditors' arrival and no new residents arrived while the auditors were on site. Therefore, the resident education, screening, and intake processes were not observed. One of the case managers walked the lead auditor through the process done at the halfway house for screening and classification and showed her the data entry screen for this information. She went over the questions and explained how she would get information from the residents. There was no demonstration of the resident education or intake processes. The auditors attempted to observe cross-gender announcements; however, at least one female staff member was consistently on site throughout the day and it was reported that the announcement had already been made. The residents in the day area were asked if the female staff announce themselves when going near the restrooms and bedrooms. They said the only female security staff work the overnight shift and they are asleep when they come on duty, but that on the occasions when female staff go into those areas during the day, they announce themselves.

The facility has two telephones in the dayroom for residents' use. The phones were tested and appeared to be working. There were bulletin boards placed above the phones with flyers for the Office of Inspector General (OIG)-Incident Reporting Center (IRC) hotline number for reporting abuse, written in both English and Spanish. If a resident who speaks a language other than English or Spanish is housed at the facility, the agency has a contract with Language Line for interpretive services. There was a locked grievance box in the dayroom for residents to place completed grievance forms and grievance forms were available in the PREA Compliance Manager's office and through the resident Grievance Clerk. The Grievance Clerk was on-site during the site review and he confirmed that he had grievance forms. Instructions for filing grievances and a TJJD brochure titled *It's Your Right to Report*

What's Wrong were posted near the grievance box. Notices of the PREA audit were posted throughout the facility on brightly colored green and yellow paper in areas visible to both the residents and staff.

During the site review, most residents were off site at work or community services. The halfway house is not a secure juvenile facility and is not required to meet the PREA required ratio of 1:8; however, agency policy requires halfway houses to maintain a 1:8 staffing ratio and the facility was observed to be in compliance with the required staffing ratio at all times. Informal conversations with residents in the dayroom, including the grievance clerk, confirmed access to grievance forms and the resident telephones. The informal conversations with residents and staff confirmed sufficient staff coverage during times when all residents were on site. During these informal conversations, residents confirmed access to telephones, as well.

Interviews

The site review concluded on the first day of the audit and the auditors transitioned to interviewing staff and residents. All interviews were conducted privately, in the classroom, conference room, or an empty staff office.

Staff Interviews

The facility reported 21 employees and 21 volunteers and four contractors who may have contact with residents at the time of the audit. All staff working during the on-site portion of the audit were interviewed, with a total of 16 facility staff being interviewed. Staff members were interviewed covering all three shifts. Due to the limited number of facility staff, several staff members were interviewed for more than one interview category. Three random volunteers were interviewed, covering various assignments such as religious, mentor, and interns. The facility works with four contractors including three teachers and a specialized treatment provider. School was out for summer break during the audit period, and the facility was not able to get the contact information for the teachers to schedule interviews. Therefore, the specialized treatment provider was the only contractor interviewed.

The audit team conducted the following number of interviews with facility staff for this audit:

Category of Staff	Number of Interviews Conducted
Random Staff Interviewed (Total):	11
Specialized Staff Interviewed (Total):	5
Total Staff Interviewed:	16
Specialized Staff Breakdown:	
• Facility Superintendent	1
• PREA Compliance Manager	1
• Intermediate or higher level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment:	2
• Medical staff:	1
• Mental health staff	1
• Non-medical staff involved in cross-gender strip searches or visual body cavity searches	1
• Contractors who have contact with inmates:	1

• Volunteers who have contact with inmates:	4
• Staff who perform screening for risk of victimization and abusiveness:	1
• Designated staff member charged with monitoring retaliation	1
• First responders, security staff	2
• Intake Staff	1
• Food service staff	1
• Staff on the incident review team	1

The auditors conducted interviews with the following agency level staff members:

- Executive Director
- Interim PREA Coordinator
- Director for Halfway Houses and Contract Care Facilities (Contract Administrator)
- HR Manager of Employment and Background Checks
- Manager of Training and Professional Development
- Administrative Investigator
- Director of the Administrative Investigations Division

An interview was also conducted with an investigator from the Office of Inspector General (OIG), an outside entity that conducts criminal investigations. The OIG shares administrative functions with TJJD; however, the Chief Inspector General reports to the Texas Juvenile Justice Department Board, not the TJJD Executive Director.

The agency does not employ SAFE/SANE staff to conduct forensic medical exams. The lead auditor contacted Methodist Specialty and Transplant Hospital and conducted a telephone interview with a representative there.

Resident Interviews

Using the auditor handbook as a guide, it was determined that if the facility had a population of 18 residents, a minimum of 10 of them should be interviewed. The facility identified residents in only one targeted interview category: transgender, intersex, gay, lesbian, and bisexual residents. The facility identified four residents in this category; however, during the interviews it was determined there were only three. Interviews with residents and staff and review of records and documentation during the audit did not identify any additional targeted residents to interview. The audit team interviewed a total of three targeted residents and seven random residents. (Although, all interviewed residents were asked the random interview questions, including the three targeted residents.) The random residents were selected from a roster provided by the facility. Every other resident name on the roster was selected to be interviewed. If a resident was not at the halfway house, the next name on the list was selected. The auditors ensured that at least one resident from each of the six bedrooms was interviewed.

File Review

Resident Files

On-site document review began on the afternoon of the first day of the audit and carried over to the second day. PREA related information for the residents was not contained in a single master file. Documentation was stored in separate locations and databases, but all records, including paper and electronic, were made available to the audit team. A file containing forms signed by residents to

acknowledge receipt of PREA comprehensive education was reviewed. The binder contained forms signed by all current residents and residents of the halfway house for the past 12 months.

Intake screenings and safe housing reassessments are documented electronically and the audit team was given access to these records. Records were reviewed for a total of seven residents. Medical and mental health records are stored in a separate database. Medical and mental health records were reviewed for those same seven residents. When choosing records to review, the auditors randomly selected five residents by taking every fourth name on the resident roster. Two additional names were selected from the list of targeted resident interviews. Three of the seven reviewed records were for residents that were interviewed by the audit team.

Staff Files

A total of seven personnel files were reviewed. The Human Resources (HR) department also provided a spreadsheet with information pulled from their databases for four additional staff members and four volunteers/contractors, which documented their background check histories. The personnel files and HR spreadsheet contained background check information for 11 of the 21 staff members, who were selected to represent a variety of job functions and assignments including both supervisory and line staff and both genders.

Training records are not included in the HR files. The facility provided training transcripts and training sign-in sheets for the auditors to review. The auditors reviewed the records for 11 randomly selected employees. To select records the auditors chose every other name on the provided staff roster. The records selected for review covered employees of both genders and various levels of seniority. Training records for volunteers and contractors are kept in TJJD's central office. The records for three volunteers and three contractors were reviewed.

Investigation Files

The agency reported six PREA related criminal investigations for Ayres House and no administrative investigations. The criminal investigation files were not provided for review by the OIG, but they did provide Investigative Reports summarizing the criminal investigations. Of the six reported criminal investigations, one was still pending and the summary was not supplied. One of the provided cases was for an incident involving alleged gang activity that included a sexual comment one resident made to another. A criminal case was opened due to the alleged gang activity with no criminal finding related to the sexual comment. The sexual comment was processed as a grievance by facility staff. The auditors reviewed this grievance.

One of the cases was an allegation of staff on youth sexual abuse that occurred at a different TJJD facility. This criminal case was closed as not sustained. That resident was on escape status at the time of the audit and not interviewed. An administrative investigation was opened for the allegation of staff on youth sexual abuse; however, this incident was reported to have happened at a different TJJD facility and the investigation was assigned to the applicable facility. The lead auditor reviewed this file.

The remaining cases were for resident on resident sexual misconduct not meeting the PREA definition of sexual abuse or harassment, but violated the Texas Penal Code (PC) and TJJD rules. One criminal case was for an incident of consensual sexual misconduct between two residents and two were isolated incidents of exposure. These three cases were closed with one sustained for prosecution, one not sustained, and one unfounded. In all instances but one, the alleged victim was no longer at the halfway house. The one remaining at the halfway house was interviewed by the audit team.

The facility reported zero administrative files for Ayres House during the reporting period. However, the auditor reviewed one investigation for a report made at Ayres House of an incident that occurred at a different TJJD location and two additional investigations that occurred since the last PREA audit. Two of the investigations were classified as "Sexual Contact or Sexual Intercourse with A Youth" and one was classified as "Neglect". All three reviewed investigations were determined to be unfounded by the investigator.

The auditors were granted access to a database containing grievance information. There were 48 grievances filed for the reporting period. The auditors conducted a cursory review of all 48 grievances and found none that contained allegations of sexual abuse or sexual harassment. Every third grievance in the database was reviewed, for a total of 16. All 16 grievances reflected an initial resolution was issued within 14 calendar days, averaging 8.4 days. One grievance resolution was appealed and a supervisor's resolution was issued a day later. The resident did not appeal the supervisor's resolution.

An exit conference was conducted on June 21, 2018, with the audit team and the Interim PREA Coordinator, the PREA Compliance Manager, and the Superintendent. The audit team reviewed the On-site phase of the audit with those present and outlined the next steps in the audit process.

Post Audit Phase

Following the audit, the audit team compiled facility inspection notes, interviews, and documentation data. The lead auditor followed up with the facility to request any additional clarification or documentation needed. On August 22, 2018, the lead auditor sent the interim PREA Audit Report via email to the Interim PREA Coordinator, PREA Compliance Manager, and the Superintendent. Corrective action was requested for seven unmet standards. This initiated the 180-day corrective action period. The audit team conducted a face-to-face meeting with the Interim PREA Coordinator on August 28, 2018, to discuss the unmet standards, what was needed to achieve compliance and timelines to provide required documentation and training. Communications via telephone call and email between the auditor and PREA Coordinator were maintained throughout the corrective action period. The PREA Coordinator provided periodic updates for corrective actions taken during this time and supplied requested information as it became available.

During the corrective action period, there were three notable personnel changes related to this PREA audit. The Interim PREA Coordinator was permanently made the agency's PREA Coordinator. Additionally, the Superintendent of Ayres House at the time of the on-site portion of the audit was let go and a new Superintendent was hired. Also, the agency hired a new Director for Halfway Houses and Contract Care Facilities.

The lead auditor returned to the facility on February 13, 2019 to conduct follow up related to the unmet standards. She conducted interviews with the facility PREA Compliance Manager (Assistant Superintendent), Superintendent, random staff and random residents. The auditor interviewed seven random staff and eight random residents. The final outstanding item was provided by the PREA Coordinator on February 14, 2019. The Corrective Action Period ended on February 18, 2019. The lead auditor then completed the review of the information provided by the agency and informally interviewed the new Director of Halfway Houses and Contract Care Facilities and a representative from Rape Crisis Center to determine if the agency was compliant with all standards.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

Ayres Halfway House is a medium restriction facility located in San Antonio, Texas, that serves adolescent males between the ages of ten and eighteen. Ayres House opened in 1980 and moved to the current location in 2009. Ayres House is one of seven medium restriction halfway houses operated by the Texas Juvenile Justice Department. The facility has a capacity of 24 residents and had a population of 18 residents on the first day of the audit. At the time of the on-site portion of the audit, the resident population was 47.4% Hispanic, 36.8% white, 10.5% black, and 5.2% other. There were 21 staff members employed at the facility on the first day of the audit, with 14 of them being security staff. The facility reported a total of 25 volunteers and contractors currently authorized to enter the facility.

The average length of stay for residents is reported to be two months and the average daily population is 20. The facility houses male offenders to include youth with Aftercare Alcohol and Other Drugs, Aftercare Sexual Behavior Treatment Program, Strategies for Anger Management, and Aftercare Mental Health needs. Education is provided on site through Judson ISD. Some of the residents who have obtained their diploma or GED have the opportunity to obtain employment in the community.

Ayres House is equipped with surveillance cameras throughout the facility and outside areas to ensure the safety and security of the staff and youth. The cameras can be monitored on multiple computers and can store up to 90 days of recorded material. Ayres House is comprised of 1 building with 6 dorm rooms that house up to 4 residents per room. The house also consists of a day room, dining room, kitchen, education room, group room, medicine room, and administrative offices. The residents' toilets and showers are located outside each dorm room and the entrance to these areas can be monitored from the day room.

Youth receive routine medical services from the University of Texas Medical Branch (UTMB) clinic at another TJJD secure facility, Giddings State School in Giddings, TX. For medical concerns requiring immediate attention, the resident is taken to a local medical provider in San Antonio. Sexual Assault Medical Exams are conducted at Methodist Specialty and Transplant Hospital. Administrative investigations are conducted by the Texas Juvenile Justice Department Administrative Investigations Division (AID), and criminal investigations are conducted by the Office of the Inspector General (OIG). The OIG is an outside entity, with the Chief Inspector General reporting to the Texas Juvenile Justice Department Board, not the TJJD Executive Director. The Incident Reporting Center (IRC) is maintained by the OIG for the purpose of reporting information concerning abuse, neglect, and exploitation. Youth and staff may make reports by calling the IRC, Office of the Independent Ombudsman, or by utilizing the facility grievance system.

Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category.** If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

Auditor Note: No standard should be found to be “Not Applicable” or “NA”. A compliance determination must be made for each standard.

PREA Standards Compliance Overview-Final Audit Report

Number of Standards Exceeded: 1

115.317: Hiring and Promotion Decisions

Number of Standards Met: 42

115.311: Zero tolerance
115.312: Contracting with other entities
115.313: Supervision and monitoring
115.315: Limits to cross-gender viewing and searches,
115.316: Residents with disabilities and residents who are limited English proficient
115.318: Upgrades to facilities and technology
115.321: Evidence protocol and forensic medical examinations
115.322: Policies for referrals of allegations for investigations
115.331: Employee training
115.332: Volunteer and contractor training
115.333: Resident education
115.334: Specialized training: Investigations
115.335: Specialized training: Medical and mental health care
115.341: Obtaining information from residents
115.342: Placement of residents
115.351: Resident reporting
115.352: Exhaustion of administrative remedies
115.353: Resident access to outside support services
115.354: Third-party reporting
115.361: Staff and agency reporting
115.362: Agency protection duties
115.363: Reporting to other confinement facilities
115.364: Staff first responder duties
115.365: Coordinated response
115.366: Preservation of ability to protect residents from contact with abusers
115.367: Agency protection against retaliation
115.368: Post-allegation protective custody
115.371: Criminal and administrative investigations
115.372: Evidentiary standards for administrative investigations

115.373: Reporting to residents
115.376: Disciplinary sanctions for staff
115.377: Corrective action for contractors and volunteers
115.378: Disciplinary sanctions for residents
115.381: Medical and mental health screenings; history of sexual abuse
115.382: Access to emergency medical and mental health services
115.383: Ongoing medical and mental health care
115.386: Sexual abuse incident review
115.387: Data collection
115.388: Data review for corrective action
115.389: Data storage, publication, and destruction
115.401: Frequency and scope of audits
115.403: Audit contents and findings

Summary of Corrective Action Taken

Corrective action was required for seven standards:

- Standard 115.312 required corrective action due to two of the agency's contracts for confinement not requiring the service provider to meet the 1:8 staffing ratio during waking hours. To demonstrate compliance with Standard 115.312 the agency provided executed addendums for the two contracts that did not require the service provider to meet the 1:8 staffing ratio during waking hours. The executed addendums added the requirement that both service providers maintain a 1:8 staffing ratio during waking hours.
- Standard 115.315 required corrective action due to three documented instances where strip searches of a transgender resident were not conducted properly. To demonstrate compliance with Standard 115.315 the agency provided a memorandum from the Superintendent outlining the procedures to be followed when there are not enough staff of the appropriate gender at the facility to conduct a strip search. Additionally, training records were provided to evidence that all facility staff were trained on these procedures. The follow up interviews with staff confirmed knowledge of the procedures.
- Standards 115.321, 115.353, and 115.365 required corrective action due to provided documentation and policy indicating that the services of a victim advocate from a rape crisis center are not being offered as required. To demonstrate compliance with Standards 115.321, 115.353, and 115.365 the agency provided an updated Coordinated Response Plan, training records, amended policy, resident handouts regarding Rape Crisis Center, and an updated MOU with Rape Crisis Center. Follow up interviews with residents and staff confirmed their knowledge of Rape Crisis Center and the services they provide.
- Standards 115.361 and 115.373 required corrective action due to required notifications not being made because of confusion about who makes the notification when the alleged incident occurred at a different TJJD facility. To demonstrate compliance with Standards 115.361 and 115.373 the agency provided amended notification procedures specifying that the Superintendent or designee at the TJJD facility where the allegation was received is responsible for the notifications required under these standards. Follow up interviews with the

Superintendent and PREA Compliance Manager confirmed their knowledge of these procedures.

PREVENTION PLANNING

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.311 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA
- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following policies and documentation were reviewed:

- GAP 380.9337(a-q)
- GAP 380.9503(i)(21)
- TJJD Agency Organizational Chart
- Monitoring and Inspections Organizational Chart
- Ayres House Organizational Chart
- Resident Handbook, pages 12, 63-67
- PREA Coordinator job posting

The following individuals were interviewed:

- Interim PREA Coordinator
- Facility PREA Compliance Manager (Assistant Superintendent)

115.311(a)

TJJD policy, General Administrative Policy (GAP) 380.9337(a-q), has the stated purpose of establishing the agency's zero tolerance policy towards all forms of sexual abuse and sexual harassment. This policy contains rules covering: prevention planning, responsive planning, training and education, screening for risk of sexual victimization and abusiveness, reporting, official response following a report of alleged sexual abuse or sexual harassment, investigations, discipline, medical and mental care, sexual abuse incident reviews, data collection and storage, publication of sexual abuse data, and audits of PREA standards.

GAP 380.9337(c) contains definitions that define sexual abuse of a youth by another youth, sexual abuse of a youth by a staff member, and sexual harassment. These definitions match the PREA definitions and include specific acts or behaviors that fall under each term. Additional policy found in GAP 380.9503(i)(21) includes a definition for sexual misconduct, which is classified as a major rule violation, that does not meet the definition of sexual abuse. The resident handbook states that sexual contact in TJJD between two people is prohibited. The handbook contains a definition of sexual abuse that includes sexual harassment. Sexual harassment is defined as well. GAP 380.9337(d) provides that all conduct that meets the definition of sexual abuse and sexual harassment is prohibited and will result in administrative disciplinary action and possibly criminal prosecution. GAP 380.9337(l) is titled Discipline and it outlines disciplinary sanctions for staff, corrective action for contractors and volunteers, and interventions and disciplinary sanctions for youth.

115.311(b)

GAP 380.9337(e)(1)(A) requires the agency to designate an upper-level staff member as the agency-wide PREA Coordinator. The policy states that the PREA Coordinator must have “sufficient time and authority to develop, implement, and oversee agency efforts to comply with PREA standards.” The PREA Coordinator position for TJJD is currently vacant. The lead auditor reviewed the job posting, and PREA responsibilities are the only duties of this position. The job description outlines this individual’s authority to develop, implement and oversee agency efforts to comply with PREA standards. Until the position is filled, the agency has appointed the PREA Compliance Manager from one of the state secure facilities to serve as the Interim PREA Coordinator. During her interview, the Interim PREA Coordinator indicated that she has enough time for her PREA related responsibilities; although, it has been difficult maintaining her regular job duties and the duties of the PREA Coordinator. She stated that she believes the permanent PREA Coordinator will have will have enough time to complete the duties of the job. She acknowledged that the PREA Coordinator has been given the authority to develop, implement and oversee the agency efforts to comply with PREA.

An agency organizational chart was provided for review. According to the chart, the PREA Coordinator reports to the Director of Monitoring and Inspections. The Director of Monitoring and Inspections reports to the Chief Operating Officer who reports to the Executive Director. The placement of the Director of PREA Compliance on the organizational chart reflects that this position is an upper level staff member.

115.311(c)

GAP 380.9337(e)(1)(B) requires the agency to designate a PREA Compliance Manager at each TJJD-operated facility. The policy requires that the compliance manager have sufficient time and authority to “coordinate the facility’s efforts to comply with PREA standards.” During her interview, the Interim PREA Coordinator indicated that TJJD has 14 PREA Compliance Managers, one at each secure facility and halfway house.

A facility organizational chart indicated the PREA Compliance Manager reports to the facility Superintendent. During his interview, the facility PREA Compliance Manager indicated that he has sufficient time to complete his PREA related duties. He acknowledged that he has the authority to coordinate the facility’s efforts to comply with PREA Standards.

Conclusion

Based on review of agency policy, supplied organizational charts, and interviews with the Interim PREA Coordinator and facility PREA Compliance Manager, the auditor has determined that the agency meets all the required provisions of this standard.

Standard 115.312: Contracting with other entities for the confinement of residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.312 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity’s obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☒ Yes ☐ No ☐ NA

115.312 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. GAP 380.9337(e)(2) (page 3)
2. Contracts the agency has entered into for the confinement and care of youth
3. PREA compliance monitoring forms
4. TJJD Website

Interviews:

1. Director for Halfway Houses and Contract Facilities

115.312 (a)

TJJD's policy requires all new or renewed contracts for residential placement to comply with the PREA standards. GAP 380.9337(e)(2) states that in contracts "for residential placement of TJJD youth, TJJD includes a clause requiring the contractor to adopt and comply with applicable PREA standards."

The TJJD website indicates it contracts with nine entities. Three of these entities are foster care/group homes and are not required to comply with PREA standards. The other six are required to comply with PREA standards. The contracts for confinement and care of youth were reviewed by the audit team. The contracts with the six entities required to comply with PREA all contain language stating:

Service Provider shall comply with the Final Rule of the Prison Rape Elimination Act of 2003 (PREA) dated June 20, 2012, effective August 20, 2012 (42 U.S.C. 15601 et seq.), and with all applicable PREA standards and TJJD policies related to PREA. Service

Provider shall make itself familiar with and at all times shall observe and comply with all PREA regulations which in any manner may affect performance under this contract. Failure to comply with PREA standards, rules, regulations, and TJJD policies may result in termination of this contract.

All of these six contracts have an Exhibit A, which contains a provision outlining the staffing ratios the contracted entity is required to adhere to. Four of the contracts require staffing ratios that meet the PREA requirements. Two of these contracts allow the contracted secure juvenile facility to maintain direct care staffing ratios of 1:12 during resident waking hours, with one specifically stating, "TJJD has granted the contractor a waiver from the PREA-required ratios that go into effect October 1, 2017." These two contracts are not compliant with §115.313(c), which requires staff ratios of a minimum of 1:8 during resident waking hours. During the interview with TJJD's Director for Halfway Houses and Contract Care Facilities, she acknowledged that TJJD does not require these two entities to maintain 1:8 staffing ratios during resident waking hours.

Because the agency has entered into two contracts for confinement that do not require the contracted entity to comply with all PREA standards, the auditor is unable to find that the agency is in compliance with this provision.

115.312 (b)

The contracts with the six entities required to comply with PREA all contain language stating that, "during non-audit periods, monitoring shall be done in the same manner TJJD verifies other contract terms." The contracts state that the service provider will:

- I. Allow the TJJD/designee to perform monitoring, performance evaluations, investigations, or audits.
 1. Provide access for inspection and reproduction of all records related to services rendered under this contract that are necessary to facilitate monitoring, performance evaluations, investigations, or audits.
 2. Records include, but are not limited to, contracts, notes, real property documents, accounting/financial records, written policies and procedures, correspondence, performance evaluation data and reports, and any other information pertinent to revenues, costs, expenses, and performance of services provided under this contract belonging to either Service Provider, its subsidiaries, parent and/or affiliate(s), including subconsultants, subcontractors, employees, and any and all related parties to this contract. "Related Party" is discussed and defined below.
 3. Upon request by the TJJD, provide facilities to the TJJD/designee to perform any of the functions listed in this subsection, as well as adequate and appropriate workspace and copier.

The TJJD's Director for Halfway Houses and Contract Care Facilities described her monitoring responsibilities as conducting site visits, observing, and interviewing youth. Fourteen PREA compliance monitoring forms, covering monitoring visits from June 14, 2016 through January 30, 2018, were reviewed. The monitoring forms list areas of compliance and noncompliance during the last visit,

whether noted corrective actions were completed, and standards observed during the current visit with related comments and corrective actions.

Corrective Action:

1. Revise the contract language to reflect that all contracted facilities are required to comply with all PREA standards including the 1:8 staff-to-youth ratio during waking hours. To determine compliance, the auditor will require an executed copy of the revised contracts for review.

Verification of Corrective Action since the Interim Audit Report

The auditor gathered, analyzed, and retained the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard.

Additional Documentation Reviewed:

- Amendments to two existing contracts for confinement

Additional Interviews Conducted:

- Director for Halfway Houses and Contract Care Facilities

The auditor reviewed amendments to the two contracts that allowed the contracted secure juvenile facility to maintain direct care staffing ratios of 1:12 during resident waking hours. The amendments state that the paragraph in the contracts titled "Direct Care Staff Ratios" is amended to read: "1 direct care staff to 8 youth during waking hours and 1:16 during sleeping hours." Both amendments were signed by the Executive Director of TJJD and a representative from the service provider. These amendments bring the agency into compliance with §115.313(c).

A follow up interview was conducted with the new Director for Halfway Houses and Contract Care Facilities, who started with the agency in January 2019. She was aware of PREA and the requirement that contracted facilities maintain a ratio of 1:8 during waking hours.

Based upon the amendments to the two existing contracts for confinement that were out of compliance with this standard and the interview with the Director for Halfway Houses and Contract Care Facilities, the auditor finds the agency in compliance with this standard.

Standard 115.313: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.313 (a)

- Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No
- Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against

sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors? ☒ Yes ☐ No

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No
- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No ☒ NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA
- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA
- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA
- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA
- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA
- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA
- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)
3. HWH Operations Manual-09.01(a)
4. Safe Housing Staffing Plan for Ayres Halfway House
5. PREA-Compliance Tracking Logs (for unannounced visits) that include the staff member's name, time, and observation notes.
6. Video Review of Unannounced Rounds

Interviews:

1. Superintendent
2. PREA Compliance Manager
3. Intermediate or Higher-Level Facility Staff
4. Informal interviews with staff and residents

115.313 (a)

TJJD policy, GAP 380.9337(e)(3)(A), requires each facility to develop and implement a written staffing plan to provide adequate levels of staffing and video monitoring to protect youth against sexual abuse. Policy does not specifically require that the agency take into consideration items (1) through (11) of this provision; however, the current *Safe Housing Staffing Plan for Ayres Halfway House* states that the staffing plan is developed and approved considering items (1) through (11) of this provision. The current staffing plan includes signatures indicating approval by the Superintendent, Director of Halfway Houses and Facility Supports, and the PREA Coordinator.

The *Safe Housing Staffing Plan for Ayres Halfway House* was provided for review and it meets the requirements of this provision. The plan outlines the requirements of PREA and discusses the TJJD halfway house programming schedule. It discusses specific programs offered at Ayres House and the daily schedule. Video monitoring is discussed, with information regarding the number and placement of cameras and known blind spots. The plan provides the daily staffing schedule and staffing ratios, as well as considering blind spots and programming and education schedules.

During her interview, the Superintendent stated that the facility staffing plan is updated and signed yearly. She stated that she participates with TJJD Central Office staff in the development process and provides input and justifications regarding staffing needs at Ayres House. She discussed the ways the requirements of this provision are considered, such as changes needed to address findings from monitoring and inspection reports, and if there are patterns in when and where incidents occur that may require staffing changes. To check for compliance with the staffing plan, she said supervisory staff conduct unannounced rounds and randomly review cameras. The PREA Compliance Manager also stated that each item in this provision is considered when updating the facility staffing plan.

115.313 (b)

TJJD policy, 380.9337(e)(3)(A)(ii), states that deviations to the staffing plan are only permitted during limited and exigent circumstances and that any deviation and the reason for the deviation must be documented. The PAQ was answered to indicate that there were no deviations from the staffing plan in the past 12 months.

Interviews with the PREA Compliance Officer and Superintendent indicate the facility did not deviate from the staffing plan in the past 12 months. During the interview with the Superintendent, she indicated that if enough staff called in sick, it would be possible that the facility could not meet the required staffing levels. She said that if this did happen, it would be documented on a form called *Initial Report of Serious Incident*. During the site review, a resident and a JCO were informally interviewed. They both said that they did not know of any circumstances where the facility did not meet required ratios. At the time of the site review, most residents were off site at work and the facility was observed to be within ratio.

115.313 (c)

While Ayres House is not a secure juvenile facility and is not subject to the 1:8 staffing ratio required by this standard, TJJD's *Halfway House Operations Manual* (HWH) 09.01(a), requires the facility to maintain a direct care staff-to-youth ratio of 1:8 during youth waking hours and 1:12 during youth sleeping hours. Direct care staff is defined as juvenile correctional officers and other staff with sole supervision training assigned to the direct supervision of youth.

During her interview, the Superintendent confirmed the ratio required by policy and stated that the facility has not deviated from this requirement. During the audit there was a youth population of 18 and the facility was observed to be in ratio when the auditors were on site.

115.313 (d)

TJJD policy, GAP 380.9337(e)(3)(A)(iii), requires that at least once each year each facility review and document whether any adjustments are needed to the written staffing plan, prevailing staffing patterns, video monitoring and other monitoring technologies, and resources the facility has available to ensure adherence to the staffing plan

The Ayres House staffing plans reviewed by the auditors discuss staffing patterns, video monitoring, and available resources. Each plan includes staffing plan procedures, provisions, current population, reassessing for safe housing, PREA supervision requirements, and facility floor plans and camera totals. The Interim PREA Coordinator said that the Staffing Plan for the facility is reviewed and approved annually by the Facility Superintendent, the Operational Director over Halfway Houses and PREA Coordinator. To evidence yearly review, the staffing plan is certified annually through signatures from each of these administrative officials. The PREA Coordinator stated that she confers with the facility Superintendent and Central Office staff regarding actual and future staffing needs for Ayres House. Ayres House Staffing plans for the last three years were reviewed during the audit. There was no specific documentation, such as meeting minutes or emails, provided to evidence the annual review process; however, the supplied staffing plans were signed each year by the Superintendent, Director of Halfway Houses and Facility Supports, and the PREA Coordinator.

115.313 (e)

TJJD policy, 380.9337(e)(3)(C) requires managerial staff members to conduct and document unannounced rounds at least once per month on each shift. Policy also prohibits staff members from notifying other staff members that unannounced rounds are occurring.

The auditors reviewed *PREA-Compliance Tracking Logs* that include the staff member's name, shift, and observation notes. The logs indicated that unannounced rounds occurred on each shift, on random days at varying times, with no discernable patterns. While on-site, three unannounced visits, consisting of one from each shift, were chosen by the audit team for review. The PREA Compliance Manager pulled up the camera footage for the auditors to review in order to verify that the unannounced visit occurred.

Supervisory staff responsible for conducting unannounced visits said they are required to do so and document them on the *PREA-Compliance Tracking Log*. They said staff are prohibited from alerting other staff that unannounced visits are occurring and that they varied the times and routine of the rounds so they are unexpected. Random staff members said unannounced rounds occurred regularly during each shift.

During the last PREA audit, this provision required a corrective action as the facility was not conducting unannounced rounds in accordance with the PREA standard and TJJD policy, as there were none conducted during the late night shift from 10PM-6AM. During the corrective action period managerial staff at the facility provided documentation to evidence that unannounced rounds were being conducted for each shift at least once per month. This brought Ayres House into compliance with PREA Standard

115.313(e) and with TJJD policy 380.9337(e)(C). Documentation review and camera footage indicate that the facility has continued to conduct unannounced rounds covering each shift with varying times staying in compliance with PREA and TJJD policy.

Recommendation:

1. Although the Superintendent and Interim PREA Coordinator were able to articulate the staffing plan development process, and updated versions of the staffing plan are signed each year, the agency should develop a process that documents the steps in the review process and all individuals involved and outlines how all items required in this provision are considered.

Description of action taken on recommendation since the Interim Audit Report

The agency did not provide evidence of a process to document the steps in the review process as recommended. The agency PREA Coordinator provided the following response regarding this recommendation:

The Staffing Plan has been revised to include recommended information including all individuals who assisted in the development and approval of the plan. A PREA Compliance Manager (PCM) Training has been scheduled for Wednesday, March 20, 2019 and all individuals currently serving in this role at each facility or halfway house has been invited to attend. Formal training on the amended Staffing Plan is one of the topics on the agenda for the PCM training.

While the response indicates that the staffing plan has been revised to include the recommended items, a copy of the revised plan was not provided to the auditors.

Standard 115.315: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.315 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
☒ Yes ☐ No

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☒ Yes ☐ No ☐ NA

115.315 (c)

- Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No
- Does the facility document all cross-gender pat-down searches? ☒ Yes ☐ No

115.315 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No
- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No
- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☒ Yes ☐ No ☐ NA

115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No
- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.315 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No
- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)(4) (page 3)
3. GAP 380.9709 (e-g) (pages 1-2)
4. Strip Search Procedures Training Module
5. Search Procedures Training Module (pat searches)
6. Search logs
7. Staff Training Transcripts
8. Shift Report Logs

Interviews:

1. Superintendent
2. Assistant Superintendent/PREA Compliance Manager
3. Manager of Training and Professional Development
4. Random Sample of Staff
5. Random Sample of Residents
6. Non-medical Staff Involved in Cross Gender Strip or Visual Searches

115.315 (a)

TJJD policy, 380.9337(e)(4) and 380.9709(f), and the strip search training module discuss cross-gender strip searches. Both policy and the training module state that two trained staff must be present and that both staff members must be of the same gender as the youth, except in exigent circumstances.

The facility answered the PAQ to indicate that three cross-gender strip searches had been conducted in the past 12 months and none of those three involved exigent circumstances or were performed by medical staff. The logs of searches were reviewed and showed three instances, during a two month period, where a resident was strip searched with a male and a female staff present. During her interview, the Superintendent explained that the three cross-gender strip searches involved the same transgender female being strip searched with both a male and female staff member present. The Superintendent said that the transgender resident had originally expressed a preference to be searched by male staff. However, at some point during her stay at Ayres House, this resident changed her preference to be searched by female staff. Ayres House has a limited number of female security staff consisting of two female JCOs on the overnight shift and a female Superintendent. The remaining security staff members are male. The other female staff do not participate in strip searches. According to the Superintendent, on three occasions from February 2018 through April 2018, because of a lack of available female staff, and TJJD policy requiring the presence of two staff members, strip searches were conducted with the transgender resident with the female Superintendent conducting the strip search with a male staff in the room. The male staff did not stand facing the youth being searched, but

stood sideways to the procedure and would have been able to view the strip search peripherally or could have turned his head to see.

Policy, 380.9337(f)(D) states that “limited by consideration of facility and staff safety and security, TJJD honors the preference of a youth to be strip searched by a male or female staff member if the youth self-identifies as transgender or intersex and that identification is supported by collateral assessment processes.” This is supported in the strip search training module which states:

In accordance with PREA, transgender or intersex youth have the right to express a preference for which gender of staff the youth prefers to be searched by. This information is documented in a formal process and assessed monthly. Facility administration will inform staff if there is a transgender or intersex youth assigned to this facility and which gendered staff will be responsible for conducting strip searches with that youth. If the youth’s preference changes and the information is documented within the guidelines of the formalized process, facility administration will inform staff of the change so the youth’s preference may be adhered to.

The PREA Resource Center Frequently Asked Questions for this standard outlines three applicable practices for searches of transgender juvenile residents.

1. searches conducted only by medical staff
2. asking residents to identify the gender of staff with whom they would feel most comfortable conducting the search
3. searches conducted in accordance with the inmate’s gender identity.

The strip search procedures training module indicates that a transgender or intersex resident’s expressed preference for which gender of staff the youth prefers to be searched by is documented in a formal process and assessed monthly. This documentation was requested, but the Superintendent said there was none.

During his interview, the Manager of Training and Professional Development stated that the training module covers strip searches of both male and female residents; therefore, all staff are trained on searching both males and females. A staff member identified by the facility as non-medical staff involved in cross gender strip or visual searches was interviewed. She said she had been trained on cross gender strip searches. She indicated that she had not participated in any cross gender strip searches, but she would do one if she had to, such as if a male staff member was not available.

The resident involved in the three strip searches is no longer at the facility and could not be interviewed. However, there is another transgender female housed at Ayres House. That resident was interviewed. She indicated that she expressed a preference to be searched by male staff. She was aware of the limited number of females to conduct searches and said she didn’t mind being searched by a male.

The three strip searches of the transgender resident with both a female and a male staff present violate agency policy and training, and violate this provision. Therefore, the auditor is unable to find that the facility meets this provision.

115.315 (b)

TJJD policy, 380.9337(e)(4) and 380.9709(e), prohibits cross-gender pat-down searches except in exigent circumstances. Policy, 380.9709(e)(2)(E), also requires that staff members honor a youth's preference to be searched by a male or female staff member if the youth identifies as transgender or intersex.

During interviews, all interviewed youth reported being pat searched by a male staff member, with no instances of being searched by a female. The transgender female housed at Ayres House said that she expressed a preference to be searched by male staff. She was aware of the limited number of females to conduct searches and said she didn't mind being searched by a male.

Of the 11 random staff interviews, eight of these were security staff who may conduct pat down searches. Five of these staff members gave answers to indicate that cross gender pat searches are either permitted or that the lack of male staff is an exigent circumstance that would warrant a cross gender pat search. Two of the security staff stated that they have not been trained on cross gender pat searches.

Training sign-in sheets were reviewed for Ayres House staff for trainings in April 2018, indicating that 18 of the 21 staff members attended Strip Search/Pat Search Procedure training. Of the three who were not listed on the training sign-in forms, only one was a security staff member and he was newly hired in June 2018. The two staff members who indicated that they had not received training signed the sign-in sheets for this training.

While policy prohibits cross-gender pat-down searches and none were conducted during the audit period, the interviewed staff gave answers that indicated they did not understand the meaning of exigent circumstances and indicated a cross-gender pat-down search could occur if there were not enough male staff. The auditor is unable to find that the facility meets this provision.

115.315 (c)

TJJD policy, 380.9709(e)(2)(G) and (f)(2)(F), requires that all room and pat-down searches, including any performed by cross-gender staff, are documented. Search logs were provided prior to and during the on-site audit and included the youths' names, items found, reason for the search, and the staff member(s) who conducted the search. No cross-gender pat-down searches were noted and three cross-gender strip searches were logged.

115.315 (d)

TJJD policy, 380.9337(e)(4)(C), prohibits cross-gender supervision during shower and restroom routine and when youth change clothes except in exigent circumstances or when such viewing is incidental to routine room checks.

All random youth and random staff interviews indicated that the residents are able to shower, perform bodily functions, and change clothing without staff of the opposite gender viewing them. The residents and staff indicated that the residents change clothing in the restrooms. During the site review it was noted that the restrooms had a wooden door that shut completely, with no gaps. There were no cameras placed in the restrooms.

Policy, 380.9337(e)(4)(D), requires staff members of the opposite gender to announce their presence when entering the bedroom of a medium restriction facility. Staff members and youth reported the practice of announcing opposite-gender staff members is consistently followed; although, three residents said they were asleep when the female security staff members arrived and were not sure if they announced themselves. A sample of Shift Report Logs included nine notations of occurrences when opposite-gender staff members announced their presence on the dorm.

115.315 (e)

TJJD policy, 380.9337(e)(4)(B) prohibits searching or examining a transgender or intersex youth for the sole purpose of determining the youth's genital status. During random interviews, all staff members communicated an understanding of the policy and said they would never search a resident to determine their sex. The transgender female currently at Ayres House said that she had never been strip searched to determine her gender.

115.315 (f)

TJJD policy, 380.9709(e)(2)(F) and (f)(2)(F), requires pat-down and strip searches be conducted in a professional manner, and staff must not make jokes, conversation, or comments while conducting searches. The auditor reviewed both the Strip Search Procedures Training Module and the Search Procedures Training Module and both state that "throughout all searches, staff should exhibit respectful communication, consistency in technique, professionalism, and awareness of safety and security."

The facility answered the PAQ to indicate that 100% of staff had been trained on conducting cross-gender pat down searches and searches of transgender and intersex residents in a professional and respectful manner. Two of the male security staff interviewed stated that they have not been trained on cross gender pat searches. Training sign-in sheets were reviewed for Ayres House staff for trainings in April 2018, indicating that 18 of the 21 staff members attended Strip and Pat Search Procedure training. Of the three who were not listed on the training sign-in forms, only one was a security staff member and he was newly hired in June 2018. Signatures from the two staff members who indicated that they had not received training were on the sign-in sheets for this training.

Corrective Action:

1. Develop procedures in compliance with §115.315 for the facility to follow when there are not enough staff of the same gender as the resident being searched or for transgender residents, staff of the preferred gender, to conduct a strip/pat search.
2. Train staff on the procedures to follow when there are not enough staff of the same gender as the resident being searched or for transgender residents, staff of the preferred gender, to conduct a strip/pat search, and provide documentation of this training.
3. Train all Ayres House staff who may conduct pat down and/or strip searches on what constitutes an "exigent circumstance". This training should also address the issue that a lack of male staff does not constitute an exigent circumstance.
4. The auditor will require documentation of the new procedures from 1 above, and evidence of the training on items 2 and 3 above during the first four months of the corrective action period. Once documentation of training is provided, the auditor will return to Ayres House to interview staff.

Recommendation

1. The training module for strip searches states that when conducting a strip search of a transgender resident, if the youth's preference changes and the information is documented

within the guidelines of the formalized process, facility administration will inform staff of the change so the youth's preference may be adhered to. If the agency has a formalized process to document a transgender resident's preference regarding the gender of the staff conducting a search, the staff at Ayres House should be trained on this process. If the agency does not have a formalized process, it should develop one and train staff.

Verification of Corrective Action since the Interim Audit Report

The auditor gathered, analyzed, and retained the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard.

Additional Documentation Reviewed:

- Memorandum for Internal Policy, dated January 24, 2019, Subject: Pat/Strip Search Accommodations for Transgender Youth
- PREA Training Acknowledgment Form and Sign-In Sheet, Course title: Coordinated Response Plan, PREA Definitions, Cross-Gender Pat Search Training
- Common PREA Definitions sheet
- Contraband/Unauthorized Item Log
- Shift Report Logs

Additional Interviews Conducted:

- PREA Coordinator
- Superintendent
- Assistant Superintendent (PREA Compliance Manager)
- Random Sample of Staff

The PREA Coordinator provided a Memorandum from the facility Superintendent outlining the procedures when conducting pat and strip searches. The memorandum states that "to ensure that Ayres Halfway House is able to accommodate the gender preference for searches on transgender or intersex youth, designated staff members of the youth's specified preference shall be scheduled on-call to conduct searches..."

The auditor conducted follow up interviews with the Superintendent and Assistant Superintendent regarding this provision. Both were able to articulate the procedures outlined in the January 24, 2019 memorandum. Additionally, both expressed an understanding of exigent circumstances and the pat/strip search procedures.

A PREA Training Acknowledgment Form for a course titled *Coordinated Response Plan, PREA Definitions, Cross-Gender Pat Search Training* was provided. Fourteen staff members signed to acknowledge attending this training. The training included a handout of common PREA definitions including one for *Exigent Circumstances* that is identical to the PREA definitions. Follow up interviews were conducted with seven random staff. All knew the procedures for conducting pat/strip searches, including searches of transgender residents. All seven staff knew the definition of exigent circumstances and were aware that the lack of staff of the appropriate gender to conduct the search was not an exigent circumstance. The staff knew and could explain the procedures outlined in the Superintendent's January 24, 2019 memo. There were no transgender residents at the facility during the follow up to interview regarding this practice. The auditor conducted a review of shift logs and Contraband/Unauthorized Item Logs and found no cross-gender pat/strip searches.

The facility's new pat/strip search policy allows for transgender residents to be searched by staff of the preferred gender, regardless of whether there are enough staff of that gender on duty at the facility. Staff have been trained on and understand the search policy and exigent circumstances. The facility has effectively demonstrated compliance during the corrective action period with supporting documentation and interviews. The facility is now compliant with this provision.

Implementation of Recommendation

The Superintendent's January 24, 2019 memo stated that "a transgender youth's expressed preference for male or female staff to conduct the pat down or strip search will be documented accordingly on the shift report" and the Contraband/Unauthorized Item Log. The Superintendent, Assistant Superintendent, and random staff interviews confirmed knowledge and practice of this procedure. The auditor conducted a review of shift logs and Contraband/Unauthorized Item Logs and found no cross-gender pat/strip searches. There were no transgender residents at the facility during the follow up to interview regarding this practice.

Standard 115.316: Residents with disabilities and residents who are limited English proficient

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No
- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No
- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)(5) (page 4)
3. Ayres House list of Spanish translators
4. PREA Script in English and Spanish
5. PREA Orientation Training and Acknowledgment Form in English and Spanish
6. Contract with San Marcos Interpreting Service for the Deaf
7. PREA Orientation Video: Safeguarding your Sexual Safety
8. Safeguarding Your Sexual Safety Instructor's Guide
9. Resident Handbook (pages 63-69)
10. It's Your Right to Report What's Wrong brochure

Interviews:

1. TJJD Executive Director
2. Random Staff
3. Staff members who provide initial PREA training to youth

115.316 (a)

TJJD policy, GAP 380.9337(e)(5)(A) states that "TJJD takes appropriate steps to ensure that youth with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps include providing access to: (i) interpreters; and (ii) written materials provided in formats or through methods that ensure effective communication."

The auditor reviewed the agency's executed contract with San Marcos Interpreting Service for the Deaf for sign language interpreting services. A list of staff interpreters who can interpret for those who are primarily Spanish speakers was provided.

Residents and staff reported that youth watch a PREA Orientation video when they arrive at the Ron Jackson orientation unit and when they transfer to a different TJJD facility. This auditor viewed this video which was produced by the Moss Group and contains information specific to TJJD. It is divided into four parts titled: Understanding Your Rights; Zero Means Zero; Ensuring Safety; Making Reports; and Conclusion Do the Program, Be well, Stay Safe. The video features staff members and residents of TJJD discussing youth rights, the agency's zero tolerance policy for sexual abuse and sexual harassment, grooming behaviors, inappropriate behaviors, the various ways to report sexual abuse and

sexual harassment, retaliation, how the agency will respond to an allegation, sexual relationship dynamics within female juvenile facilities, and how to do well and stay safe in TJJD. This video is available in English and Spanish, with no subtitles.

Intake staff reported that when showing the video to residents, staff utilize an instruction guide. The auditors reviewed the instruction guide which outlines topics to discuss with the residents before showing them the video. After each segment of the video, the guide lists questions to ask, discussion topics, and activities. The guide includes attachments with definitions related to sexual abuse/sexual harassment and 14 basic rights of TJJD youth. The guide specifically instructs the facilitator:

In the event that a youth is limited English proficient, deaf, visually impaired, or otherwise disabled in a manner that may impact their ability to comprehend the information communicated during this portion of their orientation, staff should take the appropriate steps to ensure that the youth understands the key content from the video.

Presenting the video in this format allows the residents to ask questions and enables the facilitator to discuss the video with the residents and ensure they understand the material.

During her interview, the Executive Director said that the agency has established procedures to meet this provision by providing the residents bilingual reading materials and showing them the video which is available in both English and Spanish. She said that the agency's Special Education department works with residents with learning disabilities to make sure they understand the information they are presented.

The facility reported zero residents who are limited English proficient or who have disabilities. Additionally, the auditors' interviews with residents and staff and documentation review did not identify any residents who are limited English proficient or who have disabilities; therefore, there were no residents in this category interviewed to confirm their understanding of the agency's PREA materials. All interviewed residents, including targeted and random interviews, said they had received education on PREA and were able to articulate knowledge of the agency's zero tolerance policy and how to make a report of sexual abuse or sexual harassment. Based on these interviews, the auditor has determined that the current population of Ayres House has been presented PREA education materials in a manner that they can understand.

115.316 (b)

TJJD policy, GAP 380.9337(e)(5)(B) & (C)(i), states:

- (B) TJJD takes reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment for youth who are limited English proficient, including the use of interpreters.
- (C) When using interpreters to meet requirements of this paragraph:
 - (i) TJJD attempts to select interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary;

The auditors were provided a PREA script that is read to the residents during their orientation that gives them a brief overview of the agency's sexual abuse and sexual harassment policies. The script is written in both English and Spanish. Also during orientation, the youth receive a resident handbook containing sections titled *Zero Tolerance for Sexual Abuse* and *Making a Complaint*. These sections

discuss PREA and detail what to do if you are abused, and inform the resident how to make a report. The handbook is available in both English and Spanish. The PREA orientation video described in §115.316(a) is available in both English and Spanish. The facility utilizes bilingual staff members to serve as English/Spanish translators, and provided a list of bilingual staff.

During the site review, the audit team noted copies of a zero tolerance poster placed on bulletin boards above the resident phones. The posters were printed in both English and Spanish and listed the IRC hotline number for reporting abuse.

The facility reported zero residents who are limited English proficient or who have disabilities, and the auditors' interviews with residents and staff and review of documentation did not identify any additional targeted residents to interview; therefore, there were no limited English proficient residents to interview to confirm their understanding of the agency's PREA materials.

115.316 (c)

TJJD policy, GAP 380.9337(e)(5)(C)(ii), prohibits the use of other youth to interpret, read, or otherwise assist except in limited circumstances. Ayres House reported no occurrences of the use of youth interpreters in the last 12 months. Staff members stated they would not use youth interpreters.

During interviews with random staff, all confirmed their understanding of the policy prohibiting the use of resident interpreters. During these interviews, all staff stated that they had no knowledge of a resident being used to translate for an incident related to this standard. The facility reported zero residents with disabilities or who are limited English proficient, and the auditors' interviews with residents and staff and review of documentation did not identify any additional targeted residents to interview; therefore, there were no limited English proficient residents to interview to confirm their understanding of the agency's PREA materials.

Conclusion: Based on review of agency policy, review of resident education materials, and interviews with the Executive Director and the residents of Ayres House, the auditor has determined that the agency is in compliance with the standard.

Standard 115.317: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the

community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.317 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents? ☒ Yes ☐ No

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No
- Before hiring new employees, who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No
- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.317 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No
- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No
- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.317 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

115.317 (h)

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
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Instructions for Overall Compliance Determination Narrative

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Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)(6)(A-G)
3. PRS 02.07
4. GAP 385.8181(d)(1)
5. PRS 02.08 (f)(1)(A)(ii)
6. Employee Human Resources (HR) files
7. Disclosure of PREA Employment Standards Violation
8. Spreadsheet provided by the TJJD Human Resources Administrator showing hire date, initial and annual criminal background checks, and fingerprint dates

Interviews:

1. HR Manager of Employment and Background Checks

115.317 (a)

TJJD policy (380.9337(e)(6)(A) and PRS 02.07(e)), prohibits hiring or promoting anyone who may have contact with youth and using the services of any contractor who may have contact with youth if “the person 1) has engaged in sexual abuse in a prison, lockup, community confinement facility, juvenile facility, or other institution or 2) has been convicted or civilly or administratively adjudicated of engaging or attempting to engage in such activities.”

The HR Manager of Employment and Background Checks said that this form is completed by all applicants before they are hired, all employees upon promotion, and all employees for their yearly evaluation.

Review of the seven HR files containing background check information relevant to this standard included 2 employees hired within the past 12 months and one employee promoted within the past 12 months. The HR department also provided a spreadsheet with information pulled from their databases for four additional staff members and four volunteers/contractors, which documented their background check histories. The reviewed documentation indicated that criminal record background checks were conducted as required by the standard. Additionally, each file contained a form called *Disclosure of PREA Employment Standards Violation*. This form asks the employee/applicant the following questions:

1. Have you ever engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution? (See below definition for institution.)
2. Have you ever been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?
3. Have you ever been civilly or administratively adjudicated to have engaged in the activity described in question #2 above?

4. Have you ever been civilly or administratively adjudicated, disciplined or had any government issued license revoked or suspended for having engaged in conduct

115.317 (b)

TJJD policy 380.9337(e)(6)(B) requires that for any person who may have contact with youth, TJJD considers any incidents of sexual harassment in determining whether to hire, promote, or contract for services.

The HR Manager of Employment and Background Checks confirmed compliance with this practice during her interview. She said that if any background check or employee records contained information about sexual harassment, that information would be considered.

115.317 (c)

TJJD policy 380.9337(e)(6)(C) requires that before hiring a new employee who may have contact with youth, TJJD conducts 1) a criminal background check, 2) child abuse registry check, and 3) contact of prior institutional employers to determine any substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

During her interview, the HR Manager of Employment and Background Checks verified the practice of conducting such checks for all employees. She indicated the following checks are performed: criminal background checks through the Texas Department of Public Safety and the Federal Bureau of Investigation, a child abuse registry through the Texas Department of Family and Protective Services, and all former institutional employers are contacted for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

Forms placed in each personnel file include *Applicant's Employment Reference*, *Internal Background Review*, *Disclosure of PREA Employment Standards Violation*, and *Child Abuse Registry Check Consent Form*. All seven reviewed HR files, including two files for employees hired for in the past 12 months contained these forms. The form named *Applicant's Employment Reference* contains a section to be completed for former institutional employers. This section asks the following questions:

1. During employment, was an allegation of sexual abuse or sexual harassment substantiated against the applicant regarding a resident, youth and/or minor child?
2. During employment, was an allegation of abuse, neglect, or exploitation substantiated against the applicant regarding a resident, youth and/or minor child?
3. Did this individual resign after an allegation of sexual abuse, abuse, neglect, or exploitation was made or during an investigation?
4. Did this individual's position with your company require them to work with youth between the ages of 10 – 18?

Three of the reviewed files were for employees with prior institutional employment. This section of the *Applicant's Employment Reference* was completed for all three.

115.317 (d)

TJJD policy 380.9337(e)(6)(D) requires that before enlisting the services of a contractor who may have contact with youth, TJJD performs criminal background checks and consults the Child Abuse Registry.

The HR Manager of Employment and Background Checks confirmed in her interview that the agency performs criminal record background checks and consults child abuse registries for any contractor who may have contact with residents.

The facility reports that in the past 12 months, there were two contracts for services in the past 12 months where criminal background checks were conducted. The records for the four employees of these contractors who have contact with residents were reviewed and they reflected that criminal background checks and child abuse registry searches were conducted.

115.317 (e)

Agency policy, PRS 02.08 states that to ensure that criminal history standards are met, TJJD:

1. conducts pre-employment fingerprinting and criminal history background checks;
2. conducts criminal history background checks throughout an employee's employment; and
3. requires each employee to notify TJJD if he/she:
 - is arrested;
 - is notified of criminal charges through an indictment or other official notification; or
 - learns of a change in the status of a previously reported criminal charge.

During her interview, the HR Manager of Employment and Background Checks stated that criminal background checks are conducted for all new employees before they are hired and all existing employees have a criminal background check every year around their birthday.

The auditors reviewed seven HR files and a spreadsheet detailing background check information for four additional employees. The reviewed information indicated that criminal background checks were conducted annually for the seven employees who had been with the agency longer than 12 months. The agency has exceeded the requirements of this provision by conducting criminal background checks annually, instead of every five years as required by the provision.

115.317 (f)

TJJD policy 380.9337(e)(6)(F) requires that applicants and employees who may have contact with youth have an affirmative duty to disclose misconduct described in Subsection (a) of this standard.

The HR Manager of Employment and Background Checks confirmed that every employee is required to complete the Disclosure of PREA Employment Standards Violations before they are hired and each year when they receive their yearly evaluation.

The signed *Disclosure of PREA Employment Standards Violations*, which is placed in each personnel file, supports compliance with this subsection. Five HR files reviewed were for employees who had been with the agency over 12 months; all five had copies of this form from their most recent evaluations.

115.317 (g)

TJJD policy 380.9337(e)(6)(F) requires that material omissions regarding such misconduct or the provision of materially false information is grounds for termination of employment.

The *PREA Employment Standards Violations* form states that providing untruthful answers to the questions on the form, or failing to disclose any misconduct that would result in a 'yes' answer will be grounds for termination.

115.317 (h)

TJJD policy 380.9337(e)(6)(G) requires that unless prohibited by law, TJJD provides information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom the former employee has applied to work.

The HR Manager of Employment and Background Checks confirmed that this information would be provided to an institutional employer for whom such employee has applied to work.

Conclusion

Based on review of agency policy and HR files and interviews with the HR Manager of Employment and Background Checks, the auditor has determined that the agency exceeds this standard. The agency exceeds the requirement to conduct criminal background checks on current employees every five years, by conducting them annually on the employee's birthday.

Standard 115.318: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.318 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
☐ Yes ☐ No ☒ NA

115.318 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. GAP 380.9337(e)(7)
2. Completed PAQ
3. Email chain discussing new camera installation and attached facility layout with camera numbers.

Interviews:

1. Superintendent
2. Executive Director

115.318 (a)

Agency policy, GAP 380.9337(e)(7)(A) states that when "designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, TJJD considers the effect of the design, acquisition, expansion, or modification on the agency's ability to protect youth from sexual abuse."

The facility answered the PAQ to indicate that there were no substantial modifications or expansions of the facility. During the site review, there were no modifications or expansions noted.

The Superintendent confirmed during her interview that there had been no modifications or expansions made to the facility. During the interview with the agency Executive Director, she indicated that when modifying or expanding a facility, the agency considers camera placement, supervision and visibility constraints. She said consideration is taken as to whether residents will be placed at risk in a certain area due to an inability to supervise them properly.

115.318 (b)

Agency policy, GAP 380.9337(e)(7)(B) states that when "installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, TJJD considers how such technology may enhance the agency's ability to protect youth from sexual abuse."

The facility answered the PAQ to indicate that the facility had updated their video monitoring system since the last PREA audit. The facility provided emails between the Superintendent, the Director of Halfway Houses and Facility Supports (her supervisor at the time), the PREA Coordinator, and a member of the Information Technology (IT) team. The emails state that ten new cameras were installed. The emails specifically discuss identified blind spots in camera coverage, PREA recommendations regarding cameras, camera adjustments needed for better coverage, and repairs needed for existing cameras.

During her interview, the Superintendent stated that the video monitoring system is used to augment supervision and eliminate blind spots to enhance resident's protection from sexual abuse. During the interview with the agency Executive Director, she indicated that policy requires that fixed cameras throughout the facilities be randomly checked by senior officials and there are protocols to monitor the cameras in real time for certain situations. She indicated that the agency plans to implement the use of body cameras with audio capabilities for use by all JCO staff by the end of the year.

Conclusion

Based on review of agency policy, documentation of discussions regarding new camera placement and repairs, and interviews with the Executive Director and Superintendent, the auditor has determined that the agency meets all the required provisions of this standard.

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.321 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)
☒ Yes ☐ No ☐ NA

115.321 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA
- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National

Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,” or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No
- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No
- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No
- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No
- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? ☒ Yes ☐ No
- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.321 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No
- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.321 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. GAP 380.9337 (f)
2. HWH 17.01 (c)(2)
3. Ayres House Coordinated Response Plan

Interviews:

1. Random Staff Interviews
2. Methodist Transplant and Specialty Hospital Nursing Staff
3. PREA Coordinator
4. Random Youth Interviews
5. Rape Crisis Center PREA Coordinator

115.321 (a)

TJJD policy, GAP 380.9337(f)(1)(A), requires the agency to follow a uniform evidence protocol when responding to allegations of sexual abuse and states that the evidence protocol must be developmentally appropriate for youth.

The PAQ was answered to indicate that for evidence protocol, both agency investigators and outside investigators use *A National Protocol for Sexual Assault Medical Forensic Examinations*

Adults/Adolescents, April 2013. The agency's Administrative Investigations Division (AID) conducts administrative investigations into sexual abuse and harassment allegations involving staff members. An outside entity, the OIG, is responsible for conducting all criminal investigations.

Interviewed staff members communicated an understanding of the procedures surrounding the collection of evidence and understood that OIG and AID are responsible for conducting investigations.

115.321 (b)

TJJD policy, GAP 380.9337(f)(1)(A), requires the agency to follow a uniform evidence protocol when responding to allegations of sexual abuse and states that the evidence protocol must be developmentally appropriate for youth. For evidence protocol, both agency and outside investigators use *A National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents, April 2013*. This protocol is developmentally appropriate for youth.

115.321 (c)

TJJD policy GAP 380.9337(f)(1)(B) requires that when appropriate, TJJD transports youth who experience sexual abuse to a hospital that can provide a medical examination by a SANE or SAFE. This policy also requires that medical examinations by a SAFE/SANE are provided at no financial cost to the youth.

If such exams are necessary, the Superintendent and PREA Compliance Manager said they would call nursing staff at a TJJD security facility, Giddings State School, for guidance on where to take the victim. The lead nurse at Giddings State School said that Ayres House staff would be directed to take the youth to Methodist Children's Hospital. The lead auditor contacted Methodist Children's Hospital and was transferred to Methodist Specialty and Transplant Hospital. The lead auditor spoke with a representative from Methodist Specialty and Transplant Hospital who said that if a victim was brought to Methodist Children's Hospital, they would be taken down the street to Methodist Specialty and Transplant Hospital, which is a part of the same family of hospitals. She confirmed that Methodist Specialty and Transplant Hospital has a SANE nurse available 24 hours a day.

Since the last PREA audit, the facility has not had an instance where a resident required a SAFE/SANE exam; therefore, there was no documentation to review. The auditors confirmed this through staff and resident interviews and review of records and documentation.

115.321 (d)

The facility answered the PAQ to indicate that they attempt to make a victim advocate from a rape crisis center available to the victim, in person or by other means.

The facility provided a fully executed MOU with Rape Crisis Center in San Antonio TX. The MOU is two paragraphs long, and states:

This Memorandum of Understanding (MOU) constitutes the agreement between the Texas Juvenile Justice Department (TJJD) and your organization, Rape Crisis Center that, in accordance with federal law, youth detained in TJJD facilities will be given or are currently given access to Rape Crisis Center's crisis hotline number. This number is distributed to youth after it has been determined that the youth in question is the victim of sexual abuse and has refused the on-site counseling services offered by TJJD.

If, through the course of conversation with an employee or volunteer of Rape Crisis Center it is clear that the individual being counseled is 1) a youth at a TJJD facility, and 2) has been or may be a victim of a abuse, neglect, or exploitation occurring while detained at any TJJD facility, TJJD requests that the employee or volunteer immediately and anonymously report the allegation to the TJJD Incident Reporting Center, either via email at tjjd.irc@tjjd.texas.gov or by phone at 1-866-477-8354.

Contact was made with the PREA Coordinator for Rape Crisis Center. She confirmed there was a current MOU with TJJD and that if requested, they would provide counseling services including crisis intervention services and accompany the victim to the hospital through the forensic medical exam and police accompaniment, if requested. However, the MOU states that the number for Rape Crisis Center will not be given to the victim until after refusing TJJD counseling services. The standard requires the agency to attempt to make a victim advocate available from a rape crisis center and if a rape crisis center is not available, then the agency shall make available a qualified staff member from a community-based organization or qualified agency staff member. The agency has entered into an MOU with a rape crisis center that can provide these services; therefore, a victim advocate from a rape crisis center should be offered in all instances of sexual abuse.

During the interview with the PREA Compliance Manager, he indicated that a victim advocate would not be offered right away, but would be made available when the resident returns to the halfway house. The facility reported that there were no residents at the halfway house that had reported being sexually abused and during interviews no residents reported being sexually abused while at Ayres House, so this interview was not conducted.

115.321 (e)

Agency policy GAP 380.9337(f)(1)(C) states that when “requested by a youth who experiences sexual abuse, a victim advocate will accompany and support the youth through the forensic medical examination and investigatory interviews. The victim advocate provides emotional support, crisis intervention, information, and referrals.”

The MOU with Rape Crisis Center provided for review does not indicate what services will be provided. Additionally, the auditors reviewed the *Ayres House Coordinated Response* supplied by the agency for §115.365. The coordinated response contradicts policy by stating that the on-call mental health professional “may accompany the youth to the hospital” and “if requested by the youth after returning to the facility” arrange rape crisis counseling via telephone. The Coordinated Response does not offer the victim a victim advocate to accompany the victim through the forensic medical exam and investigatory interviews. The Halfway House Operations Manual (HWH) 17.01 (c)(2) contains the same wording as the coordinated response plan.

During the interview with the PREA Compliance Manager, he indicated that victim advocate would not be offered right away, but would be made available when the resident returns to the halfway house. The facility reported that there were no residents at the halfway house that had reported being sexually abused and during interviews no residents reported being sexually abused while at Ayres House, so this interview was not conducted. .

115.321 (f)

The auditors requested documentation to evidence that the agency has requested that the Office of Inspector General follow the requirements of paragraphs (a) through (e) of this standard; however, it was not provided. Without this documentation, the auditor is unable to determine the agency is in compliance with this provision.

115.321 (g)

The auditor is not required to audit this provision.

115.321 (h)

The agency provided training documentation for the contracted specialized treatment provider that would provide services for the purposes of this standard. The agency provided certificates of completion of a course named *PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting* through NIC, a course named *Childhood Sexual Abuse* through an organization named CE4less, *13th Annual Conference of Managing Juveniles with Sexual Behavior Problems* through Sam Houston State University, *Trauma Awareness* through CE4less, and *Trauma Screening and Assessment* through CE4less.

Corrective Action:

1. Amend the MOU with Rape Crisis Center to indicate that their services will be offered to all victims of sexual abuse regardless of whether or not the victim refuses on-site counseling services offered by TJJD.
2. Amend the Ayres House Coordinated Response Plan to require that the services of Rape Crisis Center are offered early enough so that one of their advocates can accompany and support the victim through the forensic medical examination process and investigatory interviews, if the victim chooses.
3. Train staff about the changes to the Coordinated Response Plan so that they are aware when the services of Rape Crisis Center should be offered to the victim.
4. Provide documentation to evidence that the agency has requested that the Office of Inspector General follow the requirements of paragraphs (a) through (e) of this section.
5. The auditor will require an executed copy of the amended MOU with Rape Crisis Center, the amended Ayres House Coordinated Response Plan, evidence of staff training on the changes to the Ayres House Coordinated Response Plan, and documentation to evidence that the Office of Inspector General follow the requirements of paragraphs (a) through (e) of this section. This information should be provided to the auditor during the first four months of the corrective action period. Once received, the auditor will interview facility staff regarding their training.

Recommendation:

1. Amend HWH 17.01 (c)(2) to require that the services of a victim advocate from a rape crisis center are offered early enough so that one of their advocates can accompany and support the victim through the forensic medical examination process and investigatory interviews, if the victim chooses.

Verification of Corrective Action since the Interim Audit Report

The auditor gathered, analyzed, and retained the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard.

Additional Documentation Reviewed:

- Amended MOU with rape crisis center
- Amended Ayres House Coordinated Response Plan
- Training Records
- Memo regarding OIG Adherence with PREA §115.321
- *Have You Experienced Sexual Violence* handout

Additional Interviews Conducted:

- Rape Crisis Center PREA Coordinator
- Resident follow up interviews
- Staff follow up interviews

At the close of the Corrective Action Period, the agency PREA Coordinator provided a memorandum of understanding that had been signed by the TJJD Executive Director and a TJJD attorney, but was not signed by a representative for Rape Crisis Center. The auditor followed up with the Rape Crisis Center PREA Coordinator to determine the status of the MOU. The Rape Crisis Center PREA Coordinator said that the MOU was different from their usual contracts and there were a couple items they were trying to reconcile. She said that the agency has made a “good faith effort” to complete the MOU and she expected that the MOU would get signed. The partially executed MOU deletes the portion stating, “This number is distributed to youth after it has been determined that the youth in question is the victim of sexual abuse and has refused the on-site counseling services offered by TJJD.” The MOU now states:

...upon their admission youth detained in TJJD facilities located near your organization will be given and currently have access to your rape crisis hotline number. The local rape crisis hotline number is part of the information regarding the resources available through the local rape crisis center for victims of sexual abuse that is distributed to all TJJD youth within ten (10) calendar days of their admission to a TJJD facility.

While the agency does not have a fully executed MOU with Rape Crisis Center, they have documented their efforts to secure services through Rape Crisis Center and the Rape Crisis Center PREA Coordinator confirmed these efforts.

Eight residents of Ayres House were interviewed during the follow up visit on February 13, 2019. All eight residents knew about Rape Crisis Center. They said they were given a handout during their orientation at the halfway house and that someone from Rape Crisis Center had come to Ayres House and done a presentation.

The auditor was given a copy of the handout, *Have You Experienced Sexual Violence*, which is given to the residents during orientation. The handout discusses the zero tolerance policy and gives examples of sexual assault, sexual harassment and voyeurism. It provides various methods to report an incident and lists the telephone number and mailing address for Rape Crisis Center. There is a separate business card in Spanish containing the contact information for Rape Crisis Center.

During the follow up visit, the auditor saw that the *Have You Experienced Sexual Violence* handout and Spanish business card were posted by the residents' telephones. The Rape Crisis Center PREA Coordinator said that she conducted a presentation at the halfway house. She said that while she was there, they tested the phones to ensure that the residents were able to call Rape Crisis Center.

The agency PREA Coordinator provided an amended Coordinated Response Plan dated October 23, 2018. The Coordinated Response Plan now has a section named "Victim Advocacy Services" which has a section stating:

If requested by a youth who experiences sexual abuse, a victim advocate will accompany and support the youth through the forensic medical examination and investigatory interviews. The victim advocate provides emotional support, crisis intervention, information, and referrals.

The agency provided training records indicating that 14 staff members attended Coordinated Response Plan, PREA Definitions, and Cross-Gender Pat Search Training. All seven staff interviewed for follow up remembered this training and were able to articulate their knowledge of the Coordinated Response Plan and the requirement that the services of a victim advocate should be offered to a victim of sexual abuse.

The agency provided a copy of an October 26, 2018 memorandum addressed to the Chief Inspector General and signed by the Executive Director, requesting that the Office of Inspector General comply with the provisions (a) through (e) of Standard §115.321.

Based on review of the partially executed MOU, the amended Coordinated Response Plan, training records, the *Have You Experienced Sexual Violence* handout, the October 26, 2018 memorandum to the Chief Inspector General, and interviews with the Rape Crisis Center PREA Coordinator and residents and staff, the auditor finds the agency in compliance with this standard.

Implementation of Recommendation

On October 30, 2018, the PREA Coordinator provided a copy of proposed revisions to HWH 17.01 (c)(2). These revisions were not adopted by the agency before the close of the Corrective Action Period; however, before the final audit report was issued, the agency provided documentation showing that the changes had been adopted, to be effective March 1, 2019. The updated HWH 17.01 now states that the on-call mental health professional may accompany the youth to the hospital or arrange independent rape crisis counseling, as requested by the youth (HWH 17.01 (c)(2)(B)). A new section, Victim Advocacy Services (HWH 17.01 (c)(3)(A)) was added, stating:

The on-call mental health professional asks the youth who experiences sexual abuse if the youth wants a victim advocate to accompany the youth through the forensic medical examination and investigatory interviews. The victim advocate provides emotional support, crisis intervention, information, and referrals.

Standard 115.322: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.322 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No
- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.322 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No
- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No
- Does the agency document all such referrals? ☒ Yes ☐ No

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).]
☐ Yes ☐ No ☒ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (f)(2)(A), (k)(1)
3. GAP 380.9333

Interviews:

1. TJJD Executive Director
2. Agency AID investigator
3. OIG investigator
4. TJJD website: <http://www.tjjd.texas.gov/>

115.322 (a)

TJJD policy, GAP 380.9333(a), requires the agency to conduct administrative investigations. An outside entity, the Office of Inspector General (OIG), conducts criminal investigations. The OIG shares administrative functions with TJJD; however, the Chief Inspector General reports to the Texas Juvenile Justice Department Board, not the TJJD Executive Director. Policy, GAP 380.9337(f)(2)(A) and (k)(1), establishes that the OIG will review all allegations of sexual abuse and harassment and assign each allegation to the appropriate OIG or TJJD division to complete a criminal or administrative investigation.

During the interview with the Executive Director it was confirmed that a criminal and/or administrative investigation is completed for all allegations of sexual abuse and sexual harassment. It was described how allegations are referred to the OIG who determines if the allegation is criminal or should be referred to the AID division for an administrative investigation.

The agency reported six PREA related criminal investigations for Ayres House and no administrative investigations. The OIG provided five criminal Investigative Report summaries for review. The sixth investigation was still pending and the summary was not provided. One of the cases was an allegation of staff on youth sexual abuse. An administrative investigation was conducted for this allegation; however, the alleged incident occurred at a different TJJD facility and was assigned to that facility. The remaining cases were for resident on resident sexual misconduct not meeting the PREA definition of sexual abuse or harassment, but violated the Texas Penal Code and policy TJJD.

115.322 (b)

TJJD policy GAP 380.9337(j)(1)(A) requires that all allegations of sexual abuse or harassment are reported to the OIG, which reviews, assigns, and documents each allegation. GAP 380.9333(a) and (b) provide for administrative investigations of allegations of abuse, neglect, or exploitation in programs and facilities under TJJD jurisdiction. It also states that unless specifically noted, this rule does not apply to criminal investigations conducted by the OIG.

The auditors confirmed that the policy governing both agency administrative investigations and OIG criminal investigations is posted on the TJJD website.

During interviews with OIG and AID investigative staff, it was confirmed that all allegations of sexual abuse are referred to the OIG to be reviewed and assigned as a criminal and/or administrative investigation.

115.322 (c)

The auditors reviewed the TJJD website which describes the agency Administrative Investigation Division and the Office of Inspector General and their duties. The website describes the OIG as being created by the Texas Legislature to “investigate crimes committed by the departmental employees, and crimes and delinquent conduct committed at departmental facilities.” All relevant administrative rules are published on the agency’s website, including GAP 380.9333(a) and (b) which states that the agency conducts administrative investigations involving abuse, neglect, or exploitation allegedly committed by employees, volunteers, or other individuals working in TJJD programs or facilities. The policy also states that unless specifically noted, this rule does not apply to criminal investigations conducted by the OIG.

115.322 (d)

The auditor is not required to audit this provision.

115.322 (e)

The auditor is not required to audit this provision.

Conclusion:

Based on review of agency policy and the agency website, and interviews with the OIG investigator, the agency AID investigator, and the Executive Director, the auditor finds the agency in compliance with this provision.

TRAINING AND EDUCATION

Standard 115.331: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.331 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?
☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities?
☒ Yes ☐ No
- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training?
☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No
- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (g)(1) (page 6)
3. PREA and Preventing Sexual Misconduct staff development lesson plan with course description, performance objectives, materials
4. Prison Rape Elimination Act (PREA)-ecourse
5. Gender and Sexuality: A Changing Perspective lesson plan
6. Trauma in LGBT Youth presentation
7. Juvenile Health lesson plan

Interviews:

1. Random staff members

115.331 (a)

TJJD policy, GAP 380.9337(g)(1)(A), requires that all staff members who may have contact with youth attend training that addresses each of the 11 elements in this provision.

The agency provided the auditors two courses for PREA specific training for review: *Prison Rape Elimination Act (PREA)-ecourse* and *PREA and Preventing Sexual Misconduct* classroom course. The ecourse contains sections covering the history and purpose of PREA, the agency's zero tolerance policy, the impact of sexual misconduct, definitions and terms, specific agency policies related to PREA, risk factors and signs of possible abuse, inappropriate staff behaviors, and reporting. The lead auditor reviewed this course and found that it contained all 11 elements in this provision.

The *PREA and Preventing Sexual Misconduct* classroom course contains information regarding the purpose of PREA, the agency's zero tolerance policy, how to report alleged sexual misconduct, correctional culture and sexual abuse, predatory vs. vulnerable characteristics, red flags, healthy adolescent development, common reactions of sex abuse victims, and strategies to prevent sexual assault of youth. The lead auditor reviewed this course and found that it contained all 11 elements in this provision.

The agency also offers a course named *Gender and Sexuality: A Changing Perspective*, which was reviewed by the lead auditor. This course discusses sexual orientation, gender identity, and gender expression related to issues in the juvenile justice system. It discusses strategies and communication to create a supportive and inclusive environment.

The agency provided the lesson plan for another course titled *Juvenile Health*. This course discusses the physical, neurological and psychological health of the adolescent population and the youth within TJJD. It discusses the steps direct care staff members must take when handling both routine and emergency health issues.

The auditors reviewed the training records for all Ayres House employees. The records indicated that all but one had attended either the Prison Rape Elimination Act (PREA)-ecourse or the PREA and Preventing Sexual Misconduct classroom course. The one staff member not receiving these trainings was hired in January 2018 and did take the *Juvenile Health* and the *Gender and Sexuality: A Changing Perspective* courses. These courses do not cover PREA as extensively, but they touch on all the required topics of §115.331(a). The reviewed documentation indicated that 10 of the staff members had attended the *Gender and Sexuality: A Changing Perspective* course and 15 had attended the *Juvenile Health* course.

During interviews with random staff, all reported taking at least one of the two agency PREA courses. However, four of the interviewed staff members said that they either did not recall receiving training regarding how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents LGBTQ or they said that the training was not sufficient. One employee reported not having training on how to detect and respond to signs of threatened and actual sexual abuse.

115.331 (b)

TJJD policy, GAP 380.9337(g)(1)(B) requires employees reassigned from a male-only facility to a female-only facility or vice versa to receive additional training.

Prison Rape Elimination Act (PREA)-ecourse and *PREA and Preventing Sexual Misconduct* classroom course each contain information that is tailored to working with the adolescent male population of Ayres House. These courses discuss adolescent development and youth behaviors and reactions.

The facility reported that no staff members had transferred to Ayres House from a female facility and none of the interviewed staff reported transferring from a female facility; therefore, there were no training records to review.

115.331 (c)

TJJD policy, GAP 380.9337(g)(1)(B) requires that all employees receive training annually.

The facility answered the PAQ to indicate that all 21 employees, who may have contact with residents, were trained or retrained on the PREA requirements.

The training records reviewed indicated that all employees completed PREA training annually as required by agency policy.

115.331 (d)

TJJD policy, GAP 380.9337(g)(1)(C), states that TJJD documents employee's written verification that they understand the training they have received. Both the *Prison Rape Elimination Act (PREA)-ecourse* and the *Preventing Sexual Misconduct* classroom course have a test at the end that the employee must pass to get credit for the course. The employee's electronic records are updated to reflect whether the employee passed or failed.

Conclusion:

Based on review of the agency education materials, interviews with random staff, and review of employee training records, the auditor finds the agency in compliance with this standard.

Standard 115.332: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.332 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.332 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (g)(2) (page 6)
3. Volunteer Training Manual
4. TJJD Volunteer Training PowerPoint
5. Training records
6. Volunteer training acknowledgement forms

Interviews:

1. Volunteers who have contact with youth
2. Facility Superintendent
3. Compliance Officer

115.332 (a)

TJJD policy, 380.9337(g)(2), requires that all volunteers and contractors who have direct access to youth are trained on and understand their PREA-related responsibilities and procedures.

The agency answered the PAQ to indicate that there are 25 volunteers and contractors, who may have contact with residents, currently authorized to enter the facility. The PAQ also indicated that 25 volunteers and contractors (100%), who may have contact with residents, have been trained in the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response.

A volunteer training manual was provided for review. Chapter five of this manual is titled *PREA, Harassment, Trauma* and covers multiple topics including the agency's zero-tolerance policy, applicable reporting laws and policies and common myths related to sexual misconduct. The agency provided a TJJD volunteer PowerPoint presentation that contains a slide that discusses PREA and the agency's zero tolerance policy and states that all incidents must be reported and provides the IRC hotline number.

A random sample of sign-in sheets from volunteer training sessions regarding PREA was reviewed. The sign-in sheets contained signatures from the volunteers acknowledging their attendance. The eight random sign-in sheets reviewed reflected that 19 of the facility's volunteers attended training. Additionally, a training sign-in sheet was provided to evidence that the three teachers contracted through Judson ISD attended PREA training.

Three volunteers and one contractor were interviewed. All four reported receiving PREA training and said that they understood the training. They all articulated their knowledge of the agency's zero-tolerance policy and their reporting duties.

115.332 (b)

The PAQ was answered to indicate that the level and type of training provided to volunteers and contractors is based on the services they provide and the level of contact they have with residents and that all volunteers and contractors have been notified of the agency's zero tolerance policy.

The three volunteers and one contractor interviewed all said that they had received PREA training. They all articulated their knowledge of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and their reporting duties.

115.332 (c)

The PAQ was answered to indicate that the agency maintains documentation confirming that the volunteers and contractors understood the training they received.

The training acknowledgement forms for three volunteers were reviewed, including two that were interviewed. The acknowledgement form states, "I acknowledge that I have read the annual PREA training materials provided and fully understand the expectations for TJJD Volunteers."

All three forms reviewed by the auditors were signed by the employee. Additionally, the three contracted Judson ISD teachers signed acknowledgement forms stating that they understood their PREA training, TJJD's zero tolerance policy and their reporting responsibilities.

Conclusion:

Based on review of the volunteer training manual, interviews with volunteers, and training acknowledgement forms, the auditor finds the agency in compliance with this standard.

Standard 115.333: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received such education? ☒ Yes ☐ No
- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?
☒ Yes ☐ No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

- Does the agency maintain documentation of resident participation in these education sessions?
☒ Yes ☐ No

115.333 (f)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (g)(3) (page 7)
3. PREA Orientation Training and Acknowledgement Form
4. PREA Script in English and Spanish
5. PREA Orientation Training and Acknowledgment Form in English and Spanish
6. PREA Orientation Video: Safeguarding your Sexual Safety
7. Safeguarding Your Sexual Safety Instructor's Guide
8. Resident Handbook (pages 63-69)
9. It's Your Right to Report What's Wrong brochure
10. Language Line contract

Interviews:

1. Intake staff
2. Random youth

115.333 (a)

TJJD Policy, GAP 380.9337(g)(3)(A), states that "during the admission process TJJD provides youth with age appropriate information about the agency's zero-tolerance policy and how to report incidents

of suspicions of sexual abuse, sexual harassment, or sexual activity.” The PAQ was answered to indicate that in the past 12 months, 107 youth received information at the time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment.

According to the intake staff interviewed, during orientation, youth are read a PREA script that discusses the agency’s zero-tolerance policy and the policy that every report of sexual abuse and sexual harassment will be investigated. The script directs the resident to make a report by telling any staff member, writing a grievance, or calling the Ombudsman’s Office or the IRC hotline. The number for the IRC hotline is given at this time.

Intake staff and residents said that youth watch a PREA orientation video when they arrive at the Ron Jackson orientation unit and again when they transfer to a different TJJD facility. The auditor viewed this video, which was produced by the Moss Group and contains information specific to TJJD. It is divided into five parts titled: *Understanding Your Rights*; *Zero Means Zero*; *Ensuring Safety*; *Making Reports*; and *Conclusion Do the Program, Be well, Stay Safe*. The video features staff members and residents of TJJD discussing youth rights, the agency’s zero tolerance policy for sexual abuse and sexual harassment, grooming behaviors, inappropriate behaviors, the various ways to report sexual abuse and sexual harassment, retaliation, how the agency will respond to an allegation, sexual relationship dynamics within female juvenile facilities, and how to do well and stay safe in TJJD. This video is available in English and Spanish.

The intake staff said that when showing the video to residents, staff utilize an instruction guide. The instruction guide outlines topics to discuss with the residents before showing them the video. After each segment of the video, the guide lists questions to ask, discussion topics, and activities. The guide includes attachments with definitions related to sexual abuse/sexual harassment and 14 basic rights of TJJD youth. After receiving this education, the residents sign a *PREA Orientation Training and Acknowledgment Form* to acknowledge they were read the PREA orientation script and that any questions or concerns were also explained. The resident also signs to acknowledge that they have been shown the PREA orientation video. The facility provided a binder containing copies of this signed form for all 107 residents admitted to Ayres House in the past 12 months. The auditors reviewed these forms and confirmed that all current residents had signed a form.

The intake staff and residents said that during orientation, the youth receive a resident handbook. The auditors reviewed the handbook which contains sections titled *Zero Tolerance for Sexual Abuse* and *Making a Complaint*. *Zero Tolerance for Sexual Abuse* discusses PREA, defines sexual abuse and sexual harassment, identifies sexual abuse myths, details what to do if you are abused, and explains how to keep healthy boundaries. One page of this section displays a zero tolerance poster displayed in all TJJD facilities that includes the IRC hotline number. *Making a Complaint* informs the resident to tell staff, volunteers, parents and any trusted adult; call the IRC or Independent Ombudsman hotlines; or write a grievance or letter. This section directs a resident to make a report if they are threatened after making a complaint. It also explains to the residents that they can help another resident make a complaint and that they can get help filing a complaint from whomever they feel most comfortable.

The interviewed intake staff stated that residents are provided with information about the agency’s zero-tolerance policy and how to report incidents or suspicions of sexual abuse and sexual harassment through the resident handbook and the PREA orientation video. She said that all residents watch the PREA orientation video when they are admitted to the facility and all residents sign the PREA Orientation Training and Acknowledgment Form to ensure they received the training.

All residents interviewed said that they received information about the agency's zero-tolerance policy and how to make a report. They all said they were told that they would not be punished for reporting sexual abuse or sexual harassment. Of the 10 residents interviewed, five recalled receiving this information the day they arrived. The other five could not recall when the information was provided to them.

115.333 (b)

TJJD Policy, GAP 380.9337(g)(3)(B), states that within 10 calendar days after admission, TJJD provides comprehensive, age appropriate education to youth about their rights to be free from sexual abuse, sexual harassment, and retaliation for reporting such incidents, and agency policies and procedures for responding to such incidents. " The PAQ was answered to indicate that in the past 12 months, 107 youth received comprehensive age appropriate information.

Residents and intake staff said that the education described in subsection (a) of this provision is provided to all residents at intake in the Ron Jackson orientation unit and again when they transfer to another TJJD facility. The information provided at intake is comprehensive and addresses the residents' right to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents and regarding agency policies and procedures for responding to such incidents.

The interviewed intake staff said that residents are provided with information about the agency's zero-tolerance policy and how to report incidents or suspicions of sexual abuse and sexual harassment through the resident handbook and the PREA orientation video. She said that all residents watch the PREA orientation video when they are admitted to the facility and all residents sign the PREA Orientation Training and Acknowledgment Form to ensure they received the training. She said that residents receive the PREA education the day they arrive at Ayres House.

All residents interviewed said that they watched the PREA video which told them about the agency's zero-tolerance policy and how to make a report while at Ayres House. They all said they knew of their right to be free from retaliation for reporting sexual abuse or sexual harassment. Of the 10 residents interviewed, five recalled receiving this information the day they arrived at Ayres House. The other five could not recall when the information was provided to them.

115.333 (c)

TJJD policy, GAP 380.9337(g)(3)(C), requires that TJJD provide the PREA education each time a youth transfers to a different TJJD-operated facility. The facility answered the PAQ to indicate that all youth had received PREA education within ten days of intake.

The interviewed intake staff confirmed that each time a resident transfers to Ayres House they watch the PREA orientation video and staff utilize the instructor's guide.

The resident interviews confirmed this, as all reported that they received PREA education at Ayres House, with five saying they received it the day they arrived.

The auditors reviewed the binder of *PREA Orientation Training and Acknowledgment Forms* and confirmed that all current residents had signed one.

115.333 (d)

TJJD policy, GAP 380.9337(g)(3)(D), requires that the agency provide PREA information in formats accessible to all youth including those who are limited English proficient, deaf, visually impaired, otherwise disabled, or have limited reading skills.

As discussed in Standard 115.316, the PREA orientation video and the resident handbook are available in English and Spanish. The instructor's guide for the PREA orientation video states:

In the event that a youth is limited English proficient, deaf, visually impaired, or otherwise disabled in a manner that may impact their ability to comprehend the information communicated during this portion of their orientation, staff should take the appropriate steps to ensure that the youth understands the key content from the video.

The interviewed intake staff said that discussions are initiated and questions asked of the residents that reflect if they understand the content. If a resident does not understand something, she will explain it in different ways until they understand.

The resident handbook provides written education for deaf residents, and the visually impaired residents can listen to the PREA orientation video and participate in the discussions outlined in the instructor's manual.

The Superintendent and Interim PREA Coordinator said that if a resident spoke a language other than English or Spanish, staff would contact Language Line for translation services to ensure the resident understood the PREA materials. The auditors reviewed the executed contract with Language Line.

115.333 (e)

Intake staff said that after receiving PREA education, the residents sign a *PREA Orientation Training and Acknowledgment Form*. The auditors reviewed this form. It acknowledges the resident was read the PREA orientation script and it was explained to them and that any questions or concerns were also explained. The resident also signs to acknowledge that they have been shown the *Safeguarding your Sexual Safety* video. The facility provided a binder containing copies of this signed form for all 107 residents admitted to Ayres House in the past 12 months.

115.333 (f)

During the site review, the audit team noted a zero tolerance poster placed on bulletin boards above the resident phones. The posters were printed in both English and Spanish and listed IRC hotline number for reporting abuse. There was a locked grievance box in the dayroom for residents to place completed grievance forms. Posted near the grievance box were instructions for filing grievances and a TJJD brochure titled *It's Your Right to Report What's Wrong*. The brochure lists 14 basic rights of TJJD youth and discusses the agency's zero tolerance policy and asks residents to report everything they know about any sexual assault occurring at TJJD. It explains retaliation and states that a resident cannot be retaliated against for making a report and instructs residents to report instances of retaliation. The brochure lists the hotline number for the IRC in bright, bold text.

Conclusion:

Based on review of the agency education materials, interviews with intake staff, and resident interviews, the auditor finds the agency in compliance with this standard.

Standard 115.334: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (b)

- Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA
- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA
- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA
- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (g)(4)
3. Certificates of completion of the National Institute of Corrections Training for AID and OIG investigators

Interviews:

1. Investigative staff

115.334 (a)

TJJD policy, GAP 380.9337(g)(4) requires that TJJD staff members who investigate allegations of sexual abuse receive specialized training.

The agency provided certificates of completion for all investigators, including the agency AID investigator and two OIG investigators responsible for Ayres House investigations for the *PREA: Investigating Sexual Abuse in a Confinement Setting* course through the National Institute of Corrections (NIC). This training was created by The Moss Group, Inc. and is also offered as a resource through the PREA Resource Center. The PREA Resource Center provides the following description of this course:

The curriculum contains nine modules and includes content on PREA standards relating to investigations; case law demonstrating legal liability issues for agencies, facilities, and investigators to consider when working to eliminate sexual abuse and sexual harassment in confinement settings; proper use of Miranda and Garrity warnings; trauma and victim response; processes of a forensic medical exam; first-response best practices; evidence-collection best practices in a confinement setting; techniques for interviewing male, female, and juvenile alleged victims of sexual abuse and sexual harassment; report writing techniques; and information on what prosecutors consider when determining whether to prosecute sexual abuse cases

During interviews, both the agency AID investigator and the OIG investigator confirmed that they had completed the *PREA: Investigating Sexual Abuse in a Confinement Setting* course and described the topics covered.

115.334 (b)

TJJD policy, GAP 380.9337(g)(4)(A), requires that TJJD staff members who investigate allegations of sexual abuse receive specialized training that includes interviewing juvenile sexual abuse victims, proper use of *Miranda* and *Garrity* warnings, sexual abuse evidence collection in confinement settings,

and criteria and evidence required to substantiate a case for administrative action or prosecution referral.

The *PREA: Investigating Sexual Abuse in a Confinement Setting* course contains modules covering juvenile interviewing techniques, proper use of Miranda and Garrity warnings, evidence collection in a confinement setting, and the criteria required for administrative action and prosecutorial referral. During their interviews, both investigators confirmed that the training covered these topics and described the training in these areas. The certificates of completion for *PREA: Investigating Sexual Abuse in a Confinement Setting* through the National Institute of Corrections (NIC) confirmed that the investigators completed the course.

115.334 (c)

TJJD policy, 380.9337(g)(4)(B) requires TJJD to maintain documentation that the investigators have completed training. The agency provided certificates of completion as evidence that the investigators for Ayres House have completed the required training.

115.334 (d)

The auditor is not required to audit this provision.

Conclusion

Based on review of agency policy, documentation of completed training, and interviews with agency investigators, the auditor has determined that the agency meets all the required provisions of this standard.

Standard 115.335: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.335 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? ☒ Yes ☐ No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.335 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams.) ☐ Yes ☐ No ☒ NA

115.335 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere?
☒ Yes ☐ No

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? ☒ Yes ☐ No
- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337(g)(5)
3. Certificates of Completion of PREA Training

Interviews:

1. Medical and mental health care staff

115.335 (a)

TJJD policy, GAP 380.9337(g)(5), requires that full- and part-time medical and mental health staff are trained in how to detect and assess signs of sexual abuse, preserve physical evidence, respond to victims of sexual abuse, and report allegations or suspicions of sexual abuse.

The facility answered the PAQ to indicate that all three of the medical and mental health practitioners who work regularly at this facility received the training required in this provision.

The Superintendent stated that medical and mental health staff members from the TJJD Giddings facility are responsible for providing services to the youth at Ayres House. Certificates of Completion for the online course *PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting* through the NIC were reviewed for the Giddings mental and medical health practitioners. The auditors reviewed this course. It contains sections titled *Detecting, Assessing and Responding to Signs of Sexual Abuse and Harassment*, *Preserving Evidence of Sexual Abuse*; and *Reporting Allegations and Suspicions*. All required topics are covered in this training.

Medical and mental healthcare staff members described the training they received and confirmed the training covered the topics required in this provision. They said that they also received new hire and annual PREA-related training through the agency.

115.335 (b)

This subsection is not applicable; TJJD policy requires that an off-site Sexual Assault Nurse Examiner or Sexual Assault Forensic Examiner conduct forensic medical exams.

115.335 (c)

The agency provided, and the auditor reviewed, documentation to evidence that medical and mental health care staff received the required PREA training.

115.335 (d)

TJJD policy, GAP 380.9337(g)(1)(A), requires that all staff members who may have contact with youth attend PREA training required for employees under §115.332.

During interviews with medical and mental health staff, they confirmed they had received this training. Agency training records were reviewed and they indicated that medical and mental health staff had received this training.

The agency contracts with one mental health provider for specialized treatment services. This contractor's training records were not selected for review by the auditors; however, during his interview, he confirmed that he had received the agency PREA training required for contractors under §115.332.

Conclusion

Based on review of agency policy, documentation of completed training, and interviews with medical and mental health staff, the auditor has determined that the agency meets all the required provisions of this standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.341 (a)

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No
- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

- Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No
- Is this information ascertained: During classification assessments? ☒ Yes ☐ No
- Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. PAQ
2. GAP 380.9337 (h)(1)
3. Case Management Standards (CMS) 01.75(c)(2-5)
4. Intake Screening for Potential Sexual Aggressive Behavior and/or Sexual Victimization
5. Safe Housing Assessment/Reassessments in the Correctional Care System (TJJD online database)

Interviews:

1. Random youth
2. Staff responsible for risk screening
3. Compliance Officer
4. PREA Compliance Director

115.341 (a)

TJJD policy, GAP 380.9337(h)(1)(A), requires that within 72 hours of intake and periodically throughout their confinement, an objective assessment is used to obtain information about each youth's history and behavior to reduce the risk of sexual abuse by or upon another youth. Policy also requires that information from the screening instrument is used periodically throughout the youth's stay to reassess housing and supervision assignments. According to CMS 01.75(c)(2-5), a safe housing reassessment is also completed upon facility transfer, at least once every 90 days, automatically within one day of a major rule violation proven true in a hearing, turning age 17, or following a serious suicide attempt.

On the PAQ, Ayres House reported that there were 107 residents that entered the facility within the past 12 months who were screened within 72 hours of their entry for risk of sexual victimization or risk of sexually abusing other residents. The auditor reviewed a sample of Safe Housing Assessment Reports for seven current Ayres House residents. All reviewed records reflected that Safe Housing Assessments were conducted within 72 hours of arrival at the facility. Six assessments occurred the same day the resident arrived and one occurred the day after the youth's arrival.

During the interview with the staff member that performs screening for risk of sexual victimization and abusiveness, she confirmed that the agency conducts a screening when residents transfer to Ayres House. She said that residents are usually screened immediately upon arrival, but always within 72 hours. She said the screening instrument is located in a database on the computer and they enter the data as the screening is conducted. She said the while asking the questions on the screening instrument, she will initiate conversations with the youth to probe for additional information. Of the residents interviewed, seven recalled being screened the day they arrived; three could not recall when the screening occurred.

During the last PREA audit, this provision required a corrective action due to the safe housing reassessments not being conducted within the time frames mandated by agency policy. For the seven resident records reviewed, all received reassessments as required in CMS 01.75(c)(2-5).

115.341 (b)

The PAQ was answered to indicate that the risk assessment is conducted using an objective screening tool. The auditors reviewed the safe housing reassessment and determined it to be an objective screening instrument, containing all of the elements of §115.341(c).

115.341 (c)

The intake assessments completed at the Ron Jackson O&A Unit and the reassessment form used at Ayres House were reviewed. Both forms attempt to ascertain information about the 11 elements listed in this provision.

During the interview with the staff member that performs screening for risk of sexual victimization and abusiveness, she confirmed that all 11 elements are addressed on the screening tool. She showed one of the auditors the screen where data entry is done to evidence what is asked.

115.341 (d)

The staff member that performs screening for risk of sexual victimization and abusiveness said that the initial assessment conducted at the Ron Jackson O&A Unit will consider medical and mental health screenings and classification assessments, along with reviewing court records, case files, behavioral records, and the resident's file. This information will be entered into the youth's electronic records. Any updates required during the reassessments are notated in the electronic record, as well.

115.341 (e)

TJJD policy, GAP 380.9337(h)(1)(B), states that TJJD establishes appropriate controls to prevent sensitive information obtained from these screenings from being exploited to the youth's detriment by staff or other youth.

During interviews with the PREA Coordinator, PREA Compliance Manager, and the staff member that performs screening for risk of sexual victimization, it was determined that the information from the screenings is limited to medical and mental health care staff, the youth's case manager, and supervisory staff. The lead auditor was shown a locked file cabinet where paper documents are kept. The security staff do not have keys to this file cabinet. Electronic records are password protected.

Conclusion

Based on review of agency policy, review of agency screening instruments, and interviews youth, staff, the PREA Coordinator, PREA Compliance Manager, and the staff member that performs screening for risk of sexual victimization, the auditor has determined that the agency meets all the required provisions of this standard.

Standard 115.342: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? ☒ Yes ☐ No
- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? ☒ Yes ☐ No
- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? ☒ Yes ☐ No
- Do residents in isolation receive daily visits from a medical or mental health care clinician? ☒ Yes ☐ No
- Do residents also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.342 (c)

- Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No
- Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No
- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No
- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

115.342 (f)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.342 (g)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.342 (h)

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?) ☐ Yes ☐ No ☒ NA
- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?) ☐ Yes ☐ No ☒ NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. GAP 380.9337(h)(2) (page 8)
2. GAP 380.9739
3. Correctional Care System-CCF-035/36 Safe Housing

Interviews:

1. PREA Compliance Manager
2. Superintendent
3. Staff responsible for risk screening
4. JCO staff

115.342 (a)

TJJD policy, GAP 380.9337(h)(2) requires that information obtained using the screening instrument is used to make housing, bed, program, education, and work assignments for youth.

The staff responsible for risk screening said that information obtained in the resident's assessment from §115.341 is entered into a program that determines the resident's housing level (high, medium, or low). In the TJJD halfway houses, this information is used to determine which bedroom to place the youth. The auditors viewed the electronic records (Correctional Care System-CCF-035/36 Safe Housing) for seven residents and viewed the information obtained through the screening required in §115.341. The viewed records contained all information required by 115.341, which was used to determine the resident's housing level.

During the interviews with the staff that performs screening for risk of sexual victimization and abusiveness and the PREA Compliance Manager, they stated that the resident's housing level is used to determine a resident's room assignment. Residents are placed in rooms based on housing level and other factors such as safety concerns and age. While conducting the site review, the PREA Compliance Manager was able to name the residents in each room and their housing levels. For each room, he explained why the residents were placed in particular rooms detailing residents' housing levels and considerations for age and vulnerability.

115.342 (b)

TJJD policy, GAP 380.9337(h)(2)(B) requires that except under limited situations involving self-injury, TJJD does not place youth in isolation as a means of protection.

The PAQ was answered to indicate that zero residents at risk of sexual victimization were placed in isolation. In her interview, the Superintendent stated that isolation is not used at Ayres House. During the site review, it was noted that there are no rooms set up to be used as isolation cells.

115.342 (c)

TJJD policy, GAP 380.9337(h)(2)(C), requires that lesbian, gay, bisexual, transgender, or intersex youth are not placed in particular housing, beds, or other assignments on the basis of such identification. The policy also states that TJJD does not consider such identification or status as an indicator of likelihood of being sexually abusive.

At the time of the audit there were three youth who identified as LGBTI. All three youth were interviewed and stated that they were not placed in a particular room due to identifying as LGBTI. The assessments for these residents were reviewed. All three were classified as a low housing level. The PREA Compliance Manager stated that there was no room used to house lesbian, gay, bisexual, transgender, or intersex residents. He said that room assignments for LGBTI youth are made using the same criteria as other youth. He confirmed that there is not a special housing unit for lesbian, gay, bisexual, transgender, or intersex residents. He also said that identification as LGBTI is not used as an indicator of likelihood of being sexually abusive.

115.342 (d)

TJJD policy, GAP 380.9337(h)(2)(D)(i), states that for each transgender or intersex youth, the agency:

- (i) makes a case-by-case determination when assigning the youth to a male or female facility and when making other housing and programming assignments, considering the youth's health and safety and any management or security concerns;

The PREA Compliance Manager stated that room assignments for transgender residents are made on a case by case basis and the resident's safety concerns are considered. During her interview, the transgender resident said that she was asked about any safety concerns she had. She also said she was not placed in a room for only transgender or intersex residents.

115.342 (e)

TJJD policy, GAP 380.9337(h)(2)(D)(iii), states that for transgender or intersex youth, the agency will reassess the placement and programming assignments at least twice each year to review any threats to safety experienced by the youth.

The housing assessments for the transgender resident at Ayres House were reviewed. This resident has been at TJJD for approximately 15 months and has been placed at four TJJD facilities, including Ayres House. Each time she transferred to a new facility, she received a new assessment. At each facility, another assessment was conducted 2-3 months later. There were a total of seven assessments conducted during the 15 months leading up to the audit.

The PREA Compliance Manager and the staff member that performs screening for risk of sexual victimization both said that all residents are screened upon arrival, on their birthday, and every 90 days, confirming that transgender residents are reassessed at least twice a year.

115.342 (f)

TJJD policy, GAP 380.9337(h)(2)(D)(ii), requires TJJD to consider the youth's own views concerning his or her own safety when making placement and programming assignments.

The transgender resident said that she was asked questions about her safety the first day she arrived at Ayres House and that she felt her views were given serious consideration. Both the PREA Compliance Manager and the staff member that performs screening for risk of sexual victimization both said that transgender and intersex residents' views of their safety are given consideration in room and programming assignments.

115.342 (g)

TJJD policy, GAP 380.9337(h)(2)(D)(iv), requires that transgender or intersex youth are provided the opportunity to shower separately from other youth.

The transgender resident confirmed that she is able to shower separately without other residents. Both the PREA Compliance Manager and the staff member that performs screening for risk of sexual victimization confirmed this, as well.

During the site review, it was noted that each bedroom has a bathroom outside the door. Each bathroom has one shower. The door to the bathroom can be closed completely without anyone able to see in.

115.342 (h)

The PAQ was answered to indicate that zero residents at risk of sexual victimization were placed in isolation. In her interview, the Superintendent stated that isolation is not used at Ayres House. During the site review, it was noted that there are no rooms set up to be used as isolation cells.

115.342 (i)

In her interview, the Superintendent stated that isolation is not used at Ayres House. During the site review, it was noted that there are no rooms set up to be used as isolation cells.

Conclusion

Based on review of agency policy and safe housing assessments and through interviews youth, staff, the Superintendent, PREA Compliance Manager, and the staff member that performs screening for risk of sexual victimization, the auditor has determined that the agency meets all the required provisions of this standard.

REPORTING

Standard 115.351: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No
- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? ☒ Yes ☐ No

115.351 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (i)(1-3)
3. TJJD Youth Handbook (pages 65 & 68)
4. TJJD Employee Handbook (page 6)
5. Halfway House Youth Orientation Booklet (Pages 7 & 15)
6. MOU with Rape Crisis Center
7. MOU with the Independent Ombudsman

Interviews:

1. Random staff members
2. Random youth
3. PREA Compliance Manager

115.351 (a)

TJJD policy, GAP 380.9337(i)(1-3), states that youth may report sexual abuse or harassment, retaliation, and staff neglect by: 1) filing a written grievance, 2) calling the OIG hotline, 3) telling a staff member, volunteer, or contract employee.

The resident handbook (page 65) contains a section titled *Making a Complaint* that informs the resident how to make a complaint including internal methods such as telling a staff member, calling the IRC hotline, or writing a grievance. This section directs a resident to make a report if they are threatened after making a complaint. When youth are transferred to a TJJD halfway house, they receive a Halfway House Youth Orientation Booklet. Page seven of this booklet also informs the resident how to make a complaint including internal methods such as telling a staff member, calling the IRC hotline, or writing a grievance.

Additionally, the PREA orientation video shown to residents has a section called *Making Reports* that tells residents to tell a staff member, call the hotline, or write a grievance if they have been sexually abused or harassed or are retaliated against for making a report.

During interviews, staff were able to articulate the internal ways a resident can make a report of sexual abuse or sexual harassment. The staff reported multiple internal ways for a resident to make a report. Most frequently mentioned was calling the IRC, which was named by 11 of the 12. Four staff mentioned telling a trusted staff member or volunteer, four mentioned filing a written grievance, two mentioned using the Case Manager's phone, and one mentioned mailing a letter.

The residents were also able to articulate multiple internal ways to make a report of sexual abuse or sexual harassment. Of the seven random youth interviews, all seven mentioned calling the IRC, six mentioned filing a written grievance, and five mentioned telling staff.

115.351 (b)

TJJD, GAP 380.9337(i)(1)(A)(iii), states that residents can make a report by "calling the toll-free number maintained by the Office of Independent Ombudsman (OIO), which is a separate state agency, without being heard by staff or other youth."

During the site review, a poster for the OIO, including a toll-free hotline number, was posted by the resident telephones. The OIO's phone number and address is also included in the Youth Handbook (page 68).

The Halfway House Youth Orientation Booklet (page 15) for Ayres House was reviewed by the auditors. It contains a page labeled *PREA Reporting Information-Youth Orientation Packet*. This page contains a brief discussion of the agency's zero tolerance policy and lists several numbers the youth can call. There is a section called Reporting that lists the numbers for the IRC and the OIO. Another section labeled Outside Help lists a number for San Antonio-Rape Crisis Center and the contracted mental health provider.

When calling the OIO or Rape Crisis Center, the resident can choose to remain anonymous. The MOU with Rape Crisis Center TJJD requests that the employee or volunteer immediately and anonymously report the allegation to the TJJD Incident Reporting Center. The MOU with the OIO states that the Ombudsman will notify the IRC of any alleged criminal conduct.

During his interview, the PREA Compliance Manager said that the residents can report sexual abuse by calling the OIO or Rape Crisis Center. After receiving a report, the OIO and Rape Crisis Center will contact the IRC. Of the random residents interviewed, five said they would contact the OIO, two said they would contact the IRC, two said they would contact a family member, and one said he was not aware of any outside entities to contact. Six interviewed residents said they could make a report without giving their names, and four did not know if they could.

The agency does not house residents detained solely for civil immigration purposes; therefore, the second portion of this provision is not applicable.

115.351 (c)

TJJD policy, GAP 380.9337(i)(1)(B), requires that reports made verbally, in writing, anonymously, and from third parties are accepted and must promptly be reported.

The facility answered the PAQ to indicate that verbal reports must be reported immediately to the Superintendent and to the IRC as soon as possible or within 24 hours.

The random staff interviewed all acknowledged that a report could be made verbally, in writing, anonymously, and through third parties. They all said that they documented verbal reports immediately, by the end of the shift. All interviewed residents said that they could report sexual abuse or sexual harassment in person or in writing and they all said they thought someone could make a report for them.

115.351 (d)

TJJD policy, GAP 380.9337(i)(1)(C), states that the agency provides youth with access to grievance forms.

During the interview with the PREA Compliance Manager, he confirmed that youth have access to the tools to make a written grievance. He said grievance forms are available through the facility Grievance Clerk and he keeps forms in his office to give to residents as needed. He said pencils are available at the staff desk in the day room for the residents to use. The facility reported that there were no residents at the halfway house that had reported being sexually abused and during interviews no residents reported being sexually abused, so this interview was not conducted.

During the site review it was noted that there was a locked grievance box in the dayroom for residents to place completed grievance forms. Instructions for grievances and a TJJD brochure titled *It's Your Right to Report What's Wrong* were posted near the grievance box. There was a sign out sheet near the staff desk in the dayroom for residents to obtain a pencil.

115.351 (e)

TJJD policy, GAP 380.9337(i)(1)(C), states that TJJD provides all staff with access to telephones to call the IRC if the staff member has reason to believe a youth has been the victim of sexual abuse or harassment. The PAQ was answered to indicate that staff can call the IRC or the OIO.

The Employee Handbook (page 6) requires the employee to report any youth mistreatment, whether performed by another youth or staff member. The employee is instructed to immediately contact the IRC.

Of the random staff interviewed, all said they would call the IRC to privately report sexual abuse.

Conclusion:

Based on review of agency policy, the completed PAQ; the resident, employee and halfway house handbooks; MOUs with Rape Crisis Center and the OIO; and interviews with random staff, random youth, and the PREA Compliance Manager, the auditor has determined that the agency meets all the required provisions of this standard.

Standard 115.352: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.352 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☐ Yes ☒ No ☐ NA

115.352 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)
☒ Yes ☐ No ☐ NA
- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
☒ Yes ☐ No ☐ NA
- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)
☒ Yes ☐ No ☐ NA
- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
☒ Yes ☐ No ☐ NA
- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9333
3. GAP 380.9337
4. GAP 380.9331
5. Youth Rights Policy (YRP) 05.05
6. TJJD Youth Handbook (pages 63)

Interviews:

1. Random staff members
2. Random youth

115.352 (a)

TJJD policy, GAP 380.9333 (a) provides for an Administrative Investigations Division (AID) that investigates abuse, neglect, and exploitation in programs and facilities under TJJD jurisdiction. The agency is not exempt from this standard.

115.352 (b)

TJJD policy, GAP 380.9337 (i)(2)(A) states that TJJD investigates all allegations of sexual abuse regardless of how much time has passed since the alleged incident. GAP 380.9337(i)(2)(A) states that youth are not required to use the youth grievance system or the informal conference request system to report an allegation of sexual abuse and that youth are not required to attempt to resolve the allegation with staff. The agency grievance policy, 380.9331(c)(2) states that in no case is a youth required to submit a request for conference as a preliminary step prior to submitting a grievance.

Page 63 of the resident handbook instructs residents to report sexual abuse as soon as possible and that even if time has passed, the resident should still report. TJJD does not impose a time limit on the filing of a grievance and there was no policy or other documentation reviewed that contradicts this.

115.352 (c)

There is no specific policy stating that a resident may submit a grievance without submitting it to a staff member who is the subject of the complaint. However, the agency grievance policy, 380.9337(d) provides several methods for filing a grievance which would allow the resident to avoid submitting it to the staff member who is the subject of the complaint. This policy says that a grievance can be filed by calling the IRC, telling a TJJD staff member, or completing a grievance form. GAP 380.9337(d)(1)(C)(iii) states that the residential facilities have secure drop boxes for youth to submit completed grievance forms and that access to the drop boxes is restricted to staff members designated by the executive director or designee. Youth Rights Policy (YRP) 05.05 (c)(1)(B) states that at a halfway house, the assistant superintendent collects the grievances from locked grievance box and in the absence of the assistant superintendent, the superintendent performs that duty. If a resident wishes to file a grievance against the superintendent or assistant superintendent, they can call the IRC or make a report to a different staff member.

TJJD policy, GAP 380.9337 (i)(2)(D), states that allegations of sexual abuse are not referred to staff members who are the subject of the allegation. Additionally, GAP 380.9331(d)(2)(B) states that each grievance is assigned to a staff member who is not directly involved in the grievance.

115.352 (d)

The agency grievance policy, GAP 380.9331(a)(1), states that grievances alleging criminal violations or abuse, neglect, and exploitation are referred to law enforcement for investigation and disposition. Grievances alleging sexual abuse will be referred to the Office of Inspector General (OIG).

The OIG is a separate entity, as the Inspector General reports to the Texas Juvenile Justice Department Board, not the Executive Director of TJJD. As a separate entity, the OIG is not required to follow TJJD policy or procedure and the OIG's policy is not required to be submitted to the audit team. The OIG did provide investigative reports containing summaries of the five closed investigations classified by the agency as PREA violations. After reviewing an allegation, the OIG may determine that an agency administrative investigation is needed and the allegation will be referred to the agency's Administrative Investigations Division (AID).

The auditors reviewed a directive from the Deputy Director of the AID stating that the administrative investigator has 90 calendar days from the receipt of an allegation to final disposition. The investigator may request an extension up to 70 calendar days to complete the investigation.

The facility reported zero administrative investigations involving Ayres House staff during the reporting period. The auditors reviewed one investigation for an allegation by a resident of Ayres House of abuse

that occurred at a different TJJD facility and two additional investigations involving Ayres House staff that were completed since the last PREA audit. The three reviewed investigations were closed within 90 days, with an average of 26 calendar days. Because the investigations were closed within 90 days, there were no extensions or notifications required.

The facility reported no residents who reported a sexual abuse, and during interviews no residents disclosed reporting a sexual abuse; therefore, there were no interviews conducted with residents who reported a sexual abuse.

115.352 (e)

TJJD policy, GAP 380.9337(i)(1)(B), requires that reports made verbally, in writing, anonymously, and from third parties are accepted and must promptly be reported. The agency grievance policy, GAP 380.9331(a)(1) states that youth, parents/guardians of youth, and youth advocates have a right to file grievances concerning a youth under the jurisdiction of TJJD. The policy further states in 380.9331(d)(1)(A) that any person may submit a grievance to the IRC by telephone, email, fax, or postal service.

The PAQ was answered to indicate that if a third party, other than a parent or guardian, files a request on behalf of a resident, the agency does not require as a condition of processing the request that the alleged victim to agree to have the request filed on his or her behalf. The PAQ was also answered to indicate that when a parent or legal guardian files a request on behalf of a resident, the agency does not condition processing of the request upon the juvenile agreeing to have the request filed on his or her behalf. The auditors found no policy or documentation to contradict these answers.

The facility indicated that there were no third party reports of sexual abuse filed for Ayres House and interviews with residents and staff and documentation review did not disclose any third party reports; therefore, there are no files to review for this provision.

The random staff interviewed all acknowledged that a report could be made through third parties. All interviewed residents said that they thought someone could make a report for them.

115.352 (f)

TJJD policy, YRP 05.05(c)(2)(A), discusses emergency grievances. According to this policy, the staff member designated to collect grievances will identify any emergency grievances and assign it to the decision authority who is the facility's highest chain of command in the specific area of the issue grieved, to be resolved within 24 hours. This policy also states that the designated staff member reports all emergency grievances involving acute medical issues, immediate criminal acts (e.g., sexual assault), or other serious incidents in accordance with agency policy.

The PAQ was completed to indicate that there were zero grievances alleging substantial risk of imminent sexual abuse filed in the past 12 months and interviews with residents and staff and review of filed grievances did not disclose any third party reports; therefore, there were no files to review for this provision.

115.352 (g)

TJJD policy, GAP 380.9337, states that TJJD may not discipline a youth if the youth made a report of sexual abuse in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

The PAQ was answered to indicate that in the past 12 months, zero resident grievances alleging sexual abuse resulted in disciplinary action by the against the resident for having filed the grievance in bad faith. Additionally, the auditors did not locate any emergency grievances during their review; therefore, there were no files to review for this provision.

Conclusion:

Based on review of the completed PAQ, agency policy, and resident handbook, and interviews with random youth and random staff, the auditor has determined that the agency is in compliance with this standard.

Standard 115.353: Resident access to outside confidential support services and legal representation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessable mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No
- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? ☒ Yes ☐ No
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.353 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No
- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No
- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. GAP 380.9337
2. MOU with Rape Crisis Center
3. Resident Handbook
4. Halfway House Youth Orientation Booklet

Interviews:

1. Facility Superintendent
2. Director of the Bastrop Family Crisis Center
3. Random youth
4. Case Manager (random interview)

115.353 (a)

TJJD policy, GAP 380.9337(i)(3)(A), requires that youth have access to outside victim advocates for emotional support services related to sexual abuse by making available mailing addresses and telephone numbers.

The MOU with Rape Crisis Center was reviewed and it states that the number "is distributed to youth after it has been determined that the youth in question is the victim of sexual abuse and has refused the on-site counseling services offered by TJJD." Thus, the number for Rape Crisis Center is not readily available to the residents.

A *Halfway House Youth Orientation Booklet* was provided for review. Page 9 of the booklet contains the heading PREA Reporting Information. This page contains a section labeled Outside Help that lists a telephone number for Rape Crisis Center and a number for the contracted specialized treatment

provider. This page does not provide a mailing address for either. During the site review, it was noted that the MOU with Rape Crisis Center was posted on a bulletin board in a case manager's office. When the auditors questioned facility staff, it was determined that the MOU was posted the night before the audit. None of the materials informed the residents how they may confidentially communicate with the outside victim advocate. There were no other postings noted regarding Rape Crisis Center during the site review. After the site review, while the auditors were on site, a new posting was placed on a bulletin board in the day room that identified Rape Crisis Center and their telephone number. The posting did not describe the services provided by Rape Crisis Center, nor did it list a mailing address.

During a random interview with a facility Case Manager, she indicated that to make a confidential call, residents can request to make a private telephone call from one of the Case Managers' offices. She said the Case Manager would dial the number for the resident, then step outside, close the office door and supervise the resident from the office window without listening to the conversation.

During interviews with the residents, two said they were aware of services available outside of this facility for dealing with sexual abuse and named Rape Crisis Center. Three residents said there were no outside services available, three did not know of any services, one named the Department of Public Safety, and one named Child Protective Services. The two residents aware of Rape Crisis Center said they knew because they saw the poster in the dayroom. None of the residents were able to describe the services available for dealing with sexual abuse. The two residents who had seen the Rape Crisis Center poster said that they could talk to the people who provide these services anytime, the rest did not know. The facility reported that there were zero residents who had made an allegation of sexual abuse, and during the random resident interviews none of them said they had made such a report; therefore, there were no interviews with residents who reported a sexual abuse.

During the last PREA audit, this provision required a corrective action. The auditor required Ayres House to provide education to the residents regarding access to outside victim advocates for emotional support services related to sexual abuse. During the corrective action period, Ayres House trained residents and staff and during follow up interviews, all had improved knowledge about the services of outside victim advocates.

The agency does not house persons detained solely for civil immigration purposes; therefore, they do not provide immigrant services information.

Based on the residents' lack of knowledge of the outside victim advocate and services related to sexual abuse and the lack of education materials regarding this, the auditor has determined that the facility does not meet the requirements of this provision.

115.353 (b)

TJJD policy, 380.9337(i)(3)(A), requires that youth are informed, prior to giving them access, of the extent to which communications with outside services related to sexual abuse will be monitored and mandatorily reported. The *Halfway House Youth Orientation Booklet* did not contain any information regarding the extent communications with outside services related to sexual abuse are monitored or mandatory reporting laws. The poster for Rape Crisis Center hung in the dayroom did not contain this information either.

During interviews with the residents, one said the communications remained private, one said the communications were shared on a "need to know" basis, the remaining eight residents did not know if their conversations would be reported to or listened to by someone else. The facility reported that there were zero residents who had made an allegation of sexual abuse, and during the random resident

interviews none of them said they had made such a report; therefore, there were no interviews with residents who reported a sexual abuse.

Based on the residents' lack of knowledge of the extent to which communications with outside victim advocates will be monitored and the extent to which reports of abuse will be forwarded to authorities, the auditor has determined that the facility does not meet the requirements of this provision.

115.353 (c)

An executed MOU with Rape Crisis Center indicated an agreement was established to provide services. The auditor spoke with a representative from Rape Crisis Center who said their services had never been used by a resident of Ayres House; however, she verified that Rape Crisis Center would provide emotional support services if requested.

115.353 (d)

TJJD policy, 380.9337(i)(3)(C) requires reasonable and confidential access to youths' attorneys and parents or legal guardians.

During interviews, all residents reported having access to their attorneys and parents/legal guardians. During the interview with the PREA Compliance Manager, he indicated that the residents rarely request to speak with their attorneys. However, attorneys are allowed to visit with residents and they would be placed in a private room. Residents can privately call their attorneys from a case manager's office phone. He confirmed that confidentiality is ensured and knew of no circumstances where residents have limited access to their attorney. He said parent/guardian telephone numbers are programmed into the resident telephones, unless there is a specific reason that number is not approved for legal or disciplinary reasons. Parents are allowed to visit residents at the facility and youth can be granted off campus visits with their parents.

The facility reported that there were zero residents who had made an allegation of sexual abuse, and during the random resident interviews none of them said they had made such a report; therefore, there were no interviews with residents who reported a sexual abuse.

The audit team observed youth phones on each dorm, and confirmed by picking up the receiver, that the phones were operable.

Corrective Action:

1. Amend the MOU with Rape Crisis Center to indicate that their services will be offered to all victims of sexual abuse regardless of whether or not the victim refuses on-site counseling services offered by TJJD.
2. Provide the residents with education materials, or place postings in areas visible to the residents that contain the telephone number and mailing address for Rape Crisis Center and explain how the resident may confidentially correspond with Rape Crisis Center.
3. Educate current and future residents regarding:
 - a. The emotional support services related to sexual abuse available to them.
 - b. The extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.
4. The auditor will require an executed copy of the MOU with Rape Crisis Center, copies of the education materials and/or postings containing contact information for Rape Crisis Center and evidence of the training provided to the residents within the first four months of the corrective

action period. When the documentation is received, the auditor will interview the residents to determine their knowledge of and understanding of the training.

Verification of Corrective Action since the Interim Audit Report

The auditor gathered, analyzed, and retained the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard.

Additional Documentation Reviewed:

- Amended MOU with rape crisis center
- *Have You Experienced Sexual Violence* handout

Additional Interviews Conducted:

- Rape Crisis Center PREA Coordinator
- Resident follow up interviews

At the close of the Corrective Action Period, the agency PREA Coordinator provided a memorandum of understanding that had been signed by the TJJD Executive Director and a TJJD attorney, but was not signed by a representative for Rape Crisis Center. The auditor followed up with the Rape Crisis Center PREA Coordinator to determine the status of the MOU. The Rape Crisis Center PREA Coordinator said that the MOU was different from their usual contracts and there were a couple items they were trying to reconcile. She said that the agency has made a “good faith effort” to complete the MOU and she expected that the MOU would get signed. The partially executed MOU deletes the portion stating, “This number is distributed to youth after it has been determined that the youth in question is the victim of sexual abuse and has refused the on-site counseling services offered by TJJD.” The MOU now states:

...upon their admission youth detained in TJJD facilities located near your organization will be given and currently have access to your rape crisis hotline number. The local rape crisis hotline number is part of the information regarding the resources available through the local rape crisis center for victims of sexual abuse that is distributed to all TJJD youth within ten (10) calendar days of their admission to a TJJD facility.

While the agency does not have a fully executed MOU with Rape Crisis Center, they have documented their efforts to secure services through Rape Crisis Center and the Rape Crisis Center PREA Coordinator confirmed these efforts.

Eight residents of Ayres House were interviewed during the follow up visit on February 13, 2019. All eight residents knew about Rape Crisis Center. They said they were given a handout during their orientation at the halfway house and that someone from Rape Crisis Center had come to Ayres House and done a presentation. They expressed an understanding of the services provided by Rape Crisis Center and also were aware of the extent of the confidentiality of their conversations with staff from Rape Crisis Center and that certain disclosures may have to be reported to authorities.

While at the facility, the auditor was given a copy of the handout, *Have You Experienced Sexual Violence*, which is given to the residents during orientation. The handout discusses the zero tolerance policy and gives examples of sexual assault, sexual harassment and voyeurism. It provides various methods to report an incident and lists the telephone number and mailing address for Rape Crisis

Center. There is a separate business card in Spanish containing the contact information for Rape Crisis Center.

During the follow up visit, the auditor saw that the *Have You Experienced Sexual Violence* handout and Spanish business card were posted by the residents' telephones. The Rape Crisis Center PREA Coordinator said that she conducted a presentation at the halfway house. She said that while she was there, they tested the phones to ensure that the residents were able to call Rape Crisis Center.

Based on review of the partially executed MOU, the *Have You Experienced Sexual Violence* handout, and interviews with the Rape Crisis Center PREA Coordinator and residents, the auditor finds the agency in compliance with this standard.

Standard 115.354: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. GAP 380.9337 (i)(1)(B)
2. GAP 380.9331
3. TJJD website

115.354 (a)

TJJD policy, GAP 380.9337(i)(1)(B), states that TJJD accepts reports from third parties. The agency grievance policy, GAP 380.9331(a)(1) states that youth, parents/guardians of youth, and youth advocates have a right to file grievances concerning a youth under the jurisdiction of TJJD. The policy further states in 380.9331(d)(1)(A) that any person may submit a grievance to the IRC by telephone, email, fax, or postal service.

The auditors reviewed the TJJD website, which contains links to agency policy and informs readers about reporting options. It provides the telephone number and email address for the IRC. The website contains information related to PREA and provides links to the posters and brochures found at the facility and the Youth Handbook given to residents. All of these publications contain information on how to report sexual abuse and sexual harassment.

Conclusion:

Based on review of the agency policy and the TJJD website, the auditor has determined that the agency is in compliance with this standard.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT**Standard 115.361: Staff and agency reporting duties****All Yes/No Questions Must Be Answered by the Auditor to Complete the Report****115.361 (a)**

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No
- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No
- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No
- If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.) ☒ Yes ☐ No ☐ NA
- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337(j) (1) (A-F)

Interviews:

1. Superintendent
2. PREA Coordinator
3. PREA Compliance Manager
4. Medical/Mental Health Staff
5. Random staff

115.361 (a)

TJJD policy, GAP 380.9337(j)(1)(A-B), requires that staff members immediately report to the OIG any knowledge, suspicion, or information received regarding an incident of sexual abuse or sexual harassment. They are also required to report any incident of retaliation against youth or staff who reported such incidents and any staff neglect or violation of responsibilities that may have contributed to such an incident. This policy applies to any facility, whether or not it is operated by TJJD.

All random staff interviewed demonstrated their knowledge of their reporting responsibilities under Texas law, facility policy, and PREA regulations.

115.361 (b)

TJJD policy, GAP 380.9337(j)(1)(D), requires that all staff members must comply with mandatory child abuse reporting laws in Texas Family Code Chapter 261 and with applicable professional licensure requirements.

All random staff interviewed demonstrated their knowledge of their reporting responsibilities under Texas law, facility policy, and PREA regulations.

115.361 (c)

TJJD policy, GAP 380.9337(j)(1)(E), requires that all staff members who receive a report of alleged sexual abuse are prohibited from revealing that information to anyone other than to the extent necessary, to make treatment, investigation, and other security and management decisions.

All random staff interviewed demonstrated understanding of the requirements to keep information related to a sexual abuse confidential.

115.361 (d)

TJJD policy, GAP 380.9337(j)(1)(C), requires medical, mental health staff, clergy and attorneys whose communications may otherwise be privileged to report abuse as required by law and to inform youth of the limitations of confidentiality.

Interviews with medical and mental health care staff confirmed understanding of the reporting requirements and their obligation to inform youth of the limitations to confidentiality.

115.361 (e)

TJJD policy, GAP 380.9337(j)(1)(F), requires the facility administrator to promptly report any allegation of alleged sexual abuse to the parents or legal guardians or the alleged victim. If the alleged victim is under the conservatorship of DFPS, the report is made to DFPS.

There was one allegation of sexual abuse made by a resident of Ayres House during the reporting period. This allegation involved an incident of sexual abuse that occurred while housed at a different TJJD facility. The interviews with the Superintendent and PREA Compliance Manager confirmed understanding of the notification requirements of this provision, but a notification was not sent to the alleged victim's parents in this instance. The PREA Coordinator contacted the Superintendent where the alleged incident occurred and no notification was made by staff at that facility either. Discussions with the PREA Coordinator and the Superintendent indicated there was confusion about who was responsible for making the notification when the resident reports an allegation that happened at another facility.

Based on the confusion of staff regarding who is responsible for making the notification and the fact that the required notification was not done, the auditor is not able to find that the facility meets this provision.

115.361 (f)

TJJD policy, GAP 380.9337(j)(1)(A)(i-ii), requires that all staff members immediately report all allegations of sexual abuse and sexual harassment to the OIG. The OIG assigns all reports of alleged sexual abuse and sexual harassment, including third-party and anonymous reports, to the appropriate investigator.

During the interview with the Superintendent, she confirmed her knowledge of the reporting requirements.

The auditors reviewed files for the incidents classified by the agency as PREA related and confirmed that the appropriate notifications were made to the OIG.

Corrective Action:

1. Develop a procedure that clearly outlines who is responsible for making the notification requirements of §115.361(e) when the alleged incident occurred at a different TJJD facility.
2. Train staff responsible for making the notifications required in §115.361(e) of the procedures outlining who is responsible for making the notification when the alleged incident occurred at a different TJJD facility.

3. The auditor will require documentation of the procedures and evidence of staff training within the first four months of the corrective action period. Once received, the auditor will interview the applicable Ayres House staff.

Verification of Corrective Action since the Interim Audit Report

The auditor gathered, analyzed, and retained the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard.

Additional Documentation Reviewed:

- PREA Training Acknowledgement Form and Sign-In Sheet.
- TJJD Sexual Abuse Notification Procedures

Additional Interviews Conducted:

- Superintendent
- Assistant Superintendent/PREA Compliance Manager

The auditor reviewed TJJD Sexual Abuse Notification Procedures provided by the PREA Coordinator during the Corrective Action Period. The procedures specifically state that it is the duty of the Superintendent or designee “at the TJJD facility where the allegation/complaint was received” to make all notification required under § 115.361(e) regarding a youth’s allegation of sexual abuse at another TJJD facility. The auditor also reviewed a PREA Training Acknowledgement Form and Sign-In Sheet for a training on November 6, 2018 called Sexual Abuse Notification Procedures. The acknowledgement form was signed by the Superintendent and the Assistant Superintendent, indicating their attendance.

Interviews with the Superintendent and Assistant Superintendent confirmed their knowledge of notification procedures. The facility reported receiving no youth allegations of sexual abuse that occurred at another facility and the interviewed residents did not indicate that they had made a report; therefore, there were no records to review to determine compliance.

Based on a review of the TJJD Sexual Abuse Notification Procedures, the PREA Training Acknowledgement Form and Sign-In Sheet and interviews with the Superintendent and Assistant Superintendent, the auditor finds the facility is in compliance with this standard.

Standard 115.362: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.362 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)(2)

Interviews:

1. Agency Head
2. Superintendent
3. Random staff

115.362 (a)

TJJD policy, GAP 380.9337(j)(2), requires that upon receipt of an allegation that a youth is subject to a substantial risk of imminent sexual abuse, TJJD must take immediate action to protect the youth. The PAQ was answered to indicate that there were zero allegations that a youth was subject to a substantial risk of imminent sexual abuse in the past 12 months.

All staff members interviewed were able to explain precautions that would be taken to protect a youth at risk of imminent sexual abuse.

In the interview with TJJD's Executive Director, she said that the agency would act immediately and take action specific to that situation, such as putting the resident on a safety plan, moving a staff or resident, and not allowing the involved parties to interact. She also said facility staff would monitor for retaliation. The Superintendent said facility staff would take action immediately to ensure that the resident is safe. She said they would separate the resident from the perpetrator and make sure the resident is visible to staff at all times. She said the resident might be placed on a safety plan and would be monitored for retaliation for at least 90 days. All random staff interviewed said they would take action immediately. They said they would separate the resident from the perpetrator, report the incident to the IRC, and document the incident.

Conclusion:

Based on review of agency policy and interviews with the Executive Director, Superintendent, and facility staff, the auditor finds the agency in compliance with this standard.

Standard 115.363: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.363 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No
- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.363 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.363 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. GAP 380.9337 (j)
2. GAP 380.9337 (k)(1)

3. Facility documentation regarding allegations that a resident was abused while confined at another facility.

Interviews:

1. Superintendent
2. Compliance Officer

115.363 (a)

TJJD policy, GAP 380.9337(j)(3), requires that any staff member who receives an allegation that a youth was sexually abused while confined at another facility not operated by TJJD must immediately notify the OIG, and the OIG must notify the head of the facility where the abuse occurred. For allegations that youth was abused at another facility operated by TJJD, GAP 380.9337(j)(1) requires that staff members must immediately report to the OIG any knowledge, suspicion, or information received regarding an incident of sexual abuse or sexual harassment.

The Superintendent indicated that there was one incident where a resident at Ayres House reported sexual abuse that occurred at a different TJJD facility. The auditor reviewed the documentation of this report and saw that it was reported to the OIG.

115.363 (b)

TJJD policy, GAP 380.9337(j)(3)(B), requires that the notification will be provided as soon as possible, but no later than 72 hours after receiving the allegation.

The reviewed documentation indicated that the one allegation that a resident was abused while confined at another facility was reported to the OIG the same day, immediately after the allegation was made.

115.363 (c)

The facility maintained documentation of the one allegation that a resident was abused while confined at another facility and this documentation was provided to the auditors for review.

115.363 (d)

TJJD policy, GAP 380.9337(j)(1), requires that all staff members must immediately report all allegations of sexual abuse and sexual harassment to the OIG. Any allegation, including those received from other facilities/agencies will be reported to the OIG. Additionally, GAP 07.03 states that critical incidents, serious incidents, and the suspected mistreatment of youth must be reported immediately to the Office of Inspector General–Incident Reporting Center (IRC). Alleged sexual abuse is classified as a critical incident. These policies require that all allegations of sexual abuse, which would include those received from another facility/agency, be reported to the OIG. After reviewing an allegation, the OIG may determine that an agency administrative investigation is needed and the allegation will be referred to the agency's Administrative Investigations Division (AID).

The Executive Director confirmed that all allegations received from other facilities/agencies are investigated in accordance with standards and cited GAP 380.9337 and GAP 07.03. The Superintendent said that she had never had an instance where she was notified from another facility/agency that a resident had been abused at Ayres House, but that if she was notified she would immediately contact the IRC.

Conclusion:

Based on review of agency policy and documentation regarding allegations that a resident was abused while confined at another facility and interviews with the Executive Director and Superintendent, the auditor finds the agency in compliance with this standard.

Standard 115.364: Staff first responder duties**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report****115.364 (a)**

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?
☒ Yes ☐ No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.364 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. GAP 380.9337 (j)(4)

Interviews:

1. Security staff and non-security staff first responders
2. Random staff

115.364 (a)

TJJD policy, GAP 380.9337(j)(4) states that:

Upon learning of an allegation that a youth was sexually abused, the first staff member to respond to the report must:

- (A) separate the alleged victim and alleged abuser;
- (B) preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; and
- (C) if the alleged abuse occurs within a time period that still allows for the collection of physical evidence:
 - (i) request that the alleged victim not take any actions that could destroy physical evidence, including as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and
 - (ii) ensure that the alleged abuser does not take any actions that could destroy physical evidence.

The facility reported one allegation of sexual abuse in the past 12 months, but this incident occurred at a different TJJD facility and the requirements of this provision were not applicable. The resident who made the allegation had absconded from the facility and was not available to be interviewed.

Both of the staff interviewed as first responders indicated an understanding of their first responder duties and could describe the procedures that would be followed to protect the youth and the crime scene.

115.364 (b)

TJJD policy, GAP 380.9337(j)(4), outlines the actions to be taken by the first staff member who learns of an allegation that a youth was sexually abused, but does not distinguish the first responder duties for security staff versus non-security staff.

Both of the staff interviewed as first responders indicated an understanding of their first responder duties and could describe the procedures that would be followed to protect the youth and the crime scene. All of the random staff interviewed could describe their first responder duties as required in this standard.

Conclusion:

Based on review of agency policy, and interviews with random staff and first responders, the auditor finds the agency in compliance with this standard.

Standard 115.365: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.365 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)(5)
3. HWH.17.01
4. Ayres House Coordinated Response

Interviews:

1. Superintendent
2. PREA Compliance Director

115.365 (a)

TJJD policy, GAP 380.9337(j)(5) states that TJJD maintains a written plan to coordinate the actions taken among staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. The facility provided a written institutional plan to coordinate responses to allegations of sexual abuse. The plan includes procedures for first responders, on-duty supervisors, medical and mental health care staff, investigators, facility leadership, sexual abuse review board members, and the Compliance Officer.

The Ayres House Coordinated Response states that the on-call mental health professional “may accompany the youth to the hospital” and “if requested by the youth after returning to the facility” arrange rape crisis counseling via telephone. The Coordinated Response does not offer the victim a victim advocate to accompany the victim through the forensic medical exam and investigatory interviews. This is in violation of §115.321(d) and (e), which requires the agency to attempt to make available to the victim a victim advocate from a rape crisis center. As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews. The coordinated response plan does not offer the victim the choice of a victim advocate to accompany them.

The Halfway House Operations Manual (HWH) 17.01 (c)(2) contains the same wording as the coordinated response plan and states that the on-call mental health professional “may accompany the youth to the hospital” and “if requested by the youth after returning to the facility” arrange rape crisis counseling via telephone.

The Coordinated Response states that it is for Ayres House; however, it appears to be copied from policy and it is generic in nature and does not contain any information specific to the facility.

Corrective Action:

1. Amend the Ayres House Coordinated Response Plan to require that the services of Rape Crisis Center are offered early enough so that one of their advocates can accompany and support the victim through the forensic medical examination process and investigatory interviews, if the victim chooses.
2. The auditor will require a copy of the amended Ayres House Coordinated Response Plan to determine compliance.

Recommendation:

1. Amend HWH 17.01 (c)(2) to require that the services of a victim advocate from a rape crisis center are offered early enough so that one of their advocates can accompany and support the victim through the forensic medical examination process and investigatory interviews, if the victim chooses.
2. Personalize the coordinated response plan to be specific to Ayres House, such as including information regarding the name of the hospital where the victim will be transported and the name of the rape crisis center to be contacted.

Verification of Corrective Action since the Interim Audit Report

The auditor gathered, analyzed, and retained the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard.

Additional Documentation Reviewed:

- Amended Ayres House Coordinated Response Plan

Additional Interviews Conducted:

- Staff follow up interviews

The agency PREA Coordinator provided an amended Coordinated Response Plan dated October 23, 2018. The Coordinated Response Plan now has a section named "Victim Advocacy Services" which has a section stating:

If requested by a youth who experiences sexual abuse, a victim advocate will accompany and support the youth through the forensic medical examination and investigatory interviews. The victim advocate provides emotional support, crisis intervention, information, and referrals.

The agency provided training records indicating that 14 staff members attended Coordinated Response Plan, PREA Definitions, and Cross-Gender Pat Search Training. All seven staff interviewed for follow up remembered this training and were able to articulate their knowledge of the Coordinated Response Plan and the requirement that the services of a victim advocate should be offered to a victim of sexual abuse.

Based on review of the amended Coordinated Response Plan, training records, interviews with facility staff, the auditor finds the agency in compliance with this standard.

Implementation of Recommendation

1. On October 30, 2018, the PREA Coordinator provided a copy of proposed revisions to HWH 17.01 (c)(2). These revisions were not adopted by the agency before the close of the Corrective Action Period, however, before the final audit report was issued, the agency provided documentation showing that the changes had been adopted, to be effective March 1, 2019. The updated HWH 17.01 now states that the on-call mental health professional may accompany the youth to the hospital or arrange independent rape crisis counseling, as requested by the youth (HWH 17.01 (c)(2)(B)). A new section, Victim Advocacy Services (HWH 17.01 (c)(3)(A)) was added, stating:

The on-call mental health professional asks the youth who experiences sexual abuse if the youth wants a victim advocate to accompany the youth through the forensic medical examination and investigatory interviews. The victim advocate provides emotional support, crisis intervention, information, and referrals.

2. The agency did not provide evidence of a process to document that the Coordinated Response Plan had been amended to include information specific to Ayres House. The agency PREA Coordinator provided the following response regarding this recommendation:

Updating the Coordinated Response Plans for each facility and halfway house to include the specified information and streamlining the agencies efforts involving the local rape crisis centers is also a topic on the agenda for the upcoming PREA Compliance Manager Training scheduled for March/ 2019.

While the response indicates that the staffing plan has been revised to include the recommended items, a copy of the revised plan was not provided to the auditors.

Standard 115.366: Preservation of ability to protect residents from contact with abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.366 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Interviews:

1. Executive Director

115.366 (a)

TJJD does not enter into collective bargaining agreements. This was confirmed during the interview with the Executive Director.

115.366 (b)

The auditor is not required to audit this provision.

Conclusion: TJJD does not enter into collective bargaining agreements and is in compliance with this standard.

Standard 115.367: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.367 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No
- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.367 (b)

- Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services? ☒ Yes ☐ No

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct

and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff? ☒ Yes ☐ No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.367 (d)

- In the case of residents, does such monitoring also include periodic status checks?
☒ Yes ☐ No

115.367 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?
☒ Yes ☐ No

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)
3. Monitoring retaliation form

Interviews:

1. TJJD Executive Director
2. Superintendent
3. PREA Compliance Director
4. Staff who monitor for retaliation

115.367 (a)

TJJD policy, GAP 380.9337(j)(7) prohibits retaliation by a youth or staff member against a youth or staff member who reports or cooperates with an investigation.

The PAQ was completed to indicate that there have been no incidents of retaliation that have occurred in the past 12 months and no interviewed residents reported making a report that would require retaliation monitoring; therefore, there was no documentation to review for this standard. The PAQ also indicated that the PREA Compliance Manager was responsible for monitoring for retaliation and this was confirmed during his interview.

The facility provided a blank copy of a monitoring retaliation form used in agency facilities. The form logs the name of the staff member, the date of the retaliation follow up, the location of the follow up, and comments. The form instructions state, "Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need."

115.367 (b)

TJJD policy, GAP 380.9337(j)(7)(B), states that the agency uses multiple measures to protect youth and staff from retaliation, such as housing transfers, removal of the alleged abuser from contact with the alleged victim, and emotional support services for youth or staff who fear retaliation.

During the interview with the Executive Director, she indicated that retaliation is prohibited and that staff actively ensure that the individual is not retaliated against. Staff regularly check in with the individual and take action if needed. Possible actions include putting the resident on a safety plan, staff suspension, and moving one of the involved parties. Incidents of retaliation are handled through the agency disciplinary process and reported to the OIG.

The staff member charged with monitoring for retaliation stated that he watches the communication of youth and staff; creates safety plans for the youth; keeps the involved individuals separated in room assignments, movement, the dayroom, the van. He said he will monitor false allegations to see if they are being made to retaliate. Contact is initiated with the individual being monitored to get their input and address their concerns.

The facility indicated that there have been no incidents of retaliation that have occurred in the past 12 months and there were no residents at the facility who disclosed reporting a sexual abuse; therefore, these interviews were not conducted.

115.367 (c)

TJJD policy, GAP 380.9337(j)(7)(C)(i), requires the agency to continue monitoring for retaliation for at least 90 days following a report, except when the allegation is determined to be unfounded.

The facility Superintendent said that when retaliation is suspected, staff are notified so they are aware, a resident may be moved to a different room with more staff visibility, staff members may have a scheduling change or get moved from the facility. The staff member charged with monitoring for retaliation said that to detect possible retaliation, he will monitor false allegations to see if they are being done to retaliate against someone, he will look at outbursts directed at the youth, see if there are multiple write-ups of the youth, take note of the resident not wanting to participate in outings or activities.

115.367 (d)

TJJD policy, GAP 380.9337(j)(7)(C)(ii), requires that staff members conduct periodic status checks of the alleged victim. The staff member responsible for monitoring for retaliation stated that he would regularly check in with the alleged victim to get their input and address their concerns.

115.367 (e)

TJJD policy, GAP 380.9337(j)(7)(C)(ii), requires that staff take appropriate measures to protect any other individual who cooperates with the investigation who expresses a fear of retaliation.

During the interview with the Executive Director, she said that retaliation is strictly forbidden and that staff will actively ensure that the individual is not retaliated against. Staff will monitor individuals who cooperate with the investigation who express a fear of retaliation for at least 90 days and if retaliation occurs it is reported to the OIG.

115.367 (f)

The auditor is not required to audit this provision.

Conclusion:

Based on review of agency policy and interviews with the Executive Director, Superintendent, and the staff member charged with monitoring for retaliation, the auditor finds the agency in compliance with this standard.

Standard 115.368: Post-allegation protective custody

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)

Interviews:

1. Superintendent

115.368 (a)

TJJD policy, GAP 380.9337 (j)(8), prohibits using segregated housing to protect a youth who is alleged to have suffered sexual abuse. The PAQ was answered to indicate that zero residents who alleged to have suffered sexual abuse were placed in isolation.

In her interview, the Superintendent stated that isolation is not used at Ayres House. During the site review, it was noted that there are no rooms set up to be used as isolation cells.

Conclusion:

Based on review of agency policy, the interview with the Superintendent, and observations made while on site, the auditor finds the agency in compliance with this standard.

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA
- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
☒ Yes ☐ No
- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No
- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.371 (h)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.371 (i)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?
☒ Yes ☐ No

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?
☒ Yes ☐ No

115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?
☒ Yes ☐ No

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (k)
3. Training records for investigators
4. Administrative investigation files

Interviews:

1. Superintendent
2. PREA Coordinator
3. PREA Compliance Manager
4. Agency Investigator
5. Office of Inspector General Investigator
6. Director of the Administrative Investigations Division

115.371 (a)

TJJD policy, GAP 380.9337(k)(1), requires that investigations will be conducted promptly, thoroughly and objectively for all allegations, including third party and anonymous reports.

Criminal investigations are conducted by the Office of Inspector General (OIG), which is an outside entity. The Inspector General is appointed by and reports to the Texas Juvenile Justice Department Board, not the TJJD Executive Director. TJJD does conduct administrative investigations and there is an Administrative Investigations Division (AID) within the agency.

An interview was conducted with the AID investigator covering Ayres House. He stated that following an allegation of sexual abuse, an investigation is initiated within 24 hours. He also said that third party reports of sexual abuse and sexual harassment are not treated differently and are investigated in the same manner as other cases. While the OIG investigators work for an outside entity, the OIG investigator for Ayres House was interviewed by the audit team. He also stated that an investigation is initiated within 24 hours and that third party reports of sexual abuse and sexual harassment are not treated differently. Both investigators described how they would conduct a thorough investigation and discussed collection and review of evidence including physical and video evidence and interviewing the victim, alleged perpetrator, and witnesses.

The facility reported zero PREA related administrative investigations involving Ayres House staff during the reporting period. The auditors reviewed one investigation for an allegation by a resident of Ayres House of abuse that occurred at a different TJJD facility and two additional investigations involving Ayres House staff that were completed since the last PREA audit. The three reviewed investigations were closed in an average of 26 calendar days. The investigative files appeared thorough and contained a summary, preliminary findings, case detail including each action taken during the investigation, victims, witnesses, suspects, physical evidence, and investigative results. The OIG case summaries provided for review did not contain enough information to determine compliance with this provision. As the OIG is an outside entity, the complete investigative files are not required to be supplied to the auditor for review.

115.371 (b)

TJJD policy, GAP 380.9337(k)(1) requires the agency to use investigators who have received special training in sexual abuse investigations involving juvenile victims.

Documentation was provided to evidence that all investigators, including the two AID investigators and one OIG investigator responsible for conducting Ayres House investigations completed an online course titled *PREA: Investigating Sexual Abuse in a Confinement Setting* through the National Institute of Corrections (NIC). This course contains nine modules and includes content on PREA standards relating to investigations; case law demonstrating legal liability issues for agencies, facilities, and investigators to consider when working to eliminate sexual abuse and sexual harassment in confinement settings; proper use of Miranda and Garrity warnings; trauma and victim response; processes of a forensic medical exam; first-response best practices; evidence-collection best practices in a confinement setting; techniques for interviewing male, female, and juvenile alleged victims of sexual abuse and sexual harassment; report writing techniques; and information on what prosecutors consider when determining whether to prosecute sexual abuse cases.

During the interviews with the agency AID investigator and the OIG investigator, both confirmed that they had completed the *PREA: Investigating Sexual Abuse in a Confinement Setting* course and described the topics covered.

115.371 (c)

TJJD policy, GAP 380.9337(k)(1)(c), requires that TJJD investigators:

- (i) gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data;
- (ii) interview alleged victims, suspected perpetrators, and witnesses; and
- (iii) review prior complaints and reports of sexual abuse involving the suspected perpetrator.

The facility reported zero administrative investigations involving Ayres House staff during the reporting period. The auditors reviewed one investigation for an allegation by a resident of Ayres House of abuse that occurred at a different TJJD facility and two additional investigations involving Ayres House staff that were completed since the last PREA audit. The files described evidence reviewed, such as video evidence. None of the reviewed cases required the collection of physical or DNA evidence. The files also detailed interviews with the alleged victim, suspected perpetrators, and witnesses, and considered prior allegations of sexual abuse involving the perpetrator.

The State of Texas Retention Schedule for TJJD was reviewed and states that AID investigative files are retained for five years after the case is closed.

The OIG case summaries provided for review did not contain enough information to determine compliance with this provision. As the OIG is an outside entity, the complete investigative files are not required to be supplied to the auditor for review.

The agency AID investigator said that once notified of an investigation, he will speak with the victim, review physical evidence, review video evidence, review facility documents and prior complaints involving the alleged perpetrator, and speak with witnesses and the suspect. The OIG investigator said he would also take these actions, as well as collecting the physical evidence and initiating a SANE exam if needed.

115.371 (d)

TJJD policy, GAP 380.9337(k)(1)(D), states that investigations will not be terminated because the source of the allegation recants the allegation. Both the agency AID investigator and the OIG investigator confirmed this, saying they would continue the investigation.

115.371 (e)

TJJD policy, GAP 380.9337(k)(1)(E), states that when the quality of evidence supports criminal prosecution, TJJD may conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. Both the agency AID investigator and the OIG investigator confirmed this. The AID investigator said he has been in his current position three years and has not had to conduct a compelled interview yet.

The facility reported zero administrative investigations involving Ayres House staff during the reporting period. The auditors reviewed one investigation for an allegation by a resident of Ayres House of abuse that occurred at a different TJJD facility and two additional investigations involving Ayres House staff

that were completed since the last PREA audit. None of the reviewed files indicated that compelled interviews were conducted.

115.371 (f)

TJJD policy, GAP 380.9337(k)(1)(F), requires TJJD investigators to assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the person's status as a youth or staff. GAP 380.9337(k)(1)(G) states that TJJD does not require youth who allege sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation.

Both the agency AID investigator and the OIG investigator said they review the evidence to judge the credibility of a victim, suspect, or witness. Both investigators confirmed that a resident who alleges sexual abuse would never be required to submit to a polygraph exam or truth telling device as a condition for proceeding with the investigation. The facility reported that there were zero residents who had made an allegation of sexual abuse, and during the random resident interviews none of them said they had made such a report; therefore, there were no interviews with residents who reported a sexual abuse.

115.371 (g)

TJJD policy, GAP 380.9337(k)(1)(H), requires that administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse and that investigators document the investigation in written reports that include descriptions of the evidence, the reasoning behind credibility assessments, and investigative facts and findings.

The agency AID investigator said that administrative investigations are documented in a written report containing all relevant information (who, what, when, why) and all necessary attachments are included.

The facility reported zero administrative investigations involving Ayres House staff during the reporting period. The auditors reviewed one investigation for an allegation by a resident of Ayres House of abuse that occurred at a different TJJD facility and two additional investigations involving Ayres House staff that were completed since the last PREA audit. The reviewed files contained written reports that include descriptions of the evidence, the reasoning behind credibility assessments, and investigative facts and findings. The written reports also indicated if staff actions or failures to act contributed to the abuse.

115.371 (h)

Criminal investigations are conducted by the OIG, which is an outside entity. There were no criminal investigations provided to review. The OIG case summaries provided for review did not contain enough information to determine compliance with this provision. However, as the OIG is an outside entity, the complete investigative files are not required to be supplied to the auditor for review.

The OIG investigator confirmed that all criminal investigations are documented and contain a thorough and complete report.

115.371 (i)

TJJD policy, GAP 380.9337(k)(1)(J) states that substantiated allegations of conduct that appear to be criminal are referred for prosecution.

The PAQ was answered to indicate that there were zero sustained allegations of conduct that appear to be criminal that were referred for prosecution since the last PREA audit; therefore, there was no documentation to review for this provision.

The OIG investigator confirmed that substantiated allegations are referred for prosecution.

115.371 (j)

TJJD policy, GAP 380.9337(k)(1)(K), requires the agency to retain all written administrative investigative reports for as long as the alleged abuser is incarcerated by TJJD or employed by TJJD, plus at least five years.

The lead auditor interviewed the Director of the Administrative Investigations Division who confirmed that administrative investigation reports are kept as required by the standard. He showed the auditor the electronic filing system used by investigators starting in 2018 and the filing area for multiple years' worth of investigation files.

115.371 (k)

TJJD policy, GAP 380.9337(k)(1)(L), states that TJJD does not terminate investigations solely on the basis that the alleged abuser or victim is no longer in the custody of TJJD or employed by TJJD.

Both the agency AID investigator and the OIG investigator confirmed that investigations continue even if the alleged abuser or victim is no longer in the custody of TJJD or employed by TJJD.

115.371 (l)

The auditor is not required to audit this provision.

115.371 (m)

TJJD policy, GAP 380.9337(k)(1)(M), states that if an outside agency conducts an investigation into an allegation of sexual abuse, TJJD staff must cooperate with the outside investigators and that TJJD management will attempt to remain informed about the progress of the investigation.

The PREA Coordinator said investigators keep the facility informed about the investigation by sending a PREA final report to the facility at the conclusion of the investigation so management will know the disposition. Both the agency AID investigator and the OIG investigator said that they notify facility management of the outcome of an investigation. The Superintendent said she attempts to learn about the progress of a sexual abuse investigation and will periodically contact the applicable investigator to get information. Both she and the PREA Compliance Manager said that they don't always receive the PREA final report from the investigators.

Conclusion:

Based on review of agency policy, the interviews with the Superintendent, PREA Coordinator, PREA Compliance Manager, agency AID Investigator, OIG Investigator, and the Director of the Administrative Investigations Division, the auditor finds the agency in compliance with this standard.

Recommendation:

The agency should work with the outside investigating agency (OIG) and the agency AID to develop a process to notify facility leadership about the progress of an investigation that ensures facility leadership receive the PREA final report for all closed investigations.

Standard 115.372: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.372 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. GAP 380.9337 (k)(2)

Interviews:

1. Superintendent
2. AID Investigator

115.372 (a)

TJJD policy, GAP 380.9337(k)(2) requires that standard of proof used by the agency in administrative investigations is a preponderance of the evidence.

The interview with agency AID investigator confirmed his knowledge of the required standard of proof and that his practice was to use "preponderance of the evidence" in investigations.

The three AID investigations reviewed by the auditors all stated that preponderance of evidence was the standard of proof used by the investigator.

Conclusion:

Based on review of agency policy and AID investigations and the interview with the agency AID Investigator, the auditor finds the agency in compliance with this standard.

Standard 115.373: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.373 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.373 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident

whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?
☒ Yes ☐ No
- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?
☒ Yes ☐ No

115.373 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (k)
3. Notification form

Interviews:

1. Superintendent
2. AID Investigative Staff
3. OIG Investigative Staff

115.373 (a)

TJJD policy, GAP 380.9337(k)(3)(A), requires that until the youth is discharged from TJJD, the facility will inform the youth whether the allegation is substantiated, unsubstantiated, or unfounded.

Both the agency AID investigator and the OIG investigator said they were aware of the notification requirement of this provision. They said they notify the facility and the facility notifies the youth. The Superintendent and the PREA Compliance Manager said that they don't always receive the notification of the outcome of a sexual abuse investigation from the investigators.

There was one allegation of sexual abuse made by a resident of Ayres House during the reporting period. This allegation involved an incident of sexual abuse that occurred while housed at a different TJJD facility. The interviews with the Superintendent and PREA Compliance Manager confirmed understanding of the notification requirements of this provision, but they did not send a notification in this instance. The PREA Coordinator contacted the Superintendent where the alleged incident occurred and no notification was made by staff at that facility either. Discussions with the PREA Coordinator and the Superintendent indicated there was confusion about who was responsible for making the notification when the resident reports an allegation that happened at another facility.

Based on the confusion of staff regarding who is responsible for making the notification and the fact that the required notification was not done, the auditor is not able to find that the facility meets this provision.

115.373 (b)

TJJD policy, GAP 380.9337(k)(3)(A), states that if TJJD did not conduct the investigation, TJJD management will request the information from the investigating agency so that the youth may be informed. The PAQ indicated that an outside agency conducted one investigation of alleged resident sexual abuse. The sexual abuse investigation was not provided for review; however, a copy of the PREA final report sent to facility management was provided. The PREA final report contained a synopsis of the investigation and the disposition.

115.373 (c)

TJJD policy, GAP 380.9337(k)(3)(B), requires that youth are notified when 1) the staff member is no longer posted within the youth's unit, 2) the staff member is no longer employed at the facility, 3) when TJJD learns the staff member has been indicted on a charge related to sexual abuse, or 4) when TJJD learns that the staff member has been convicted on a charge related to sexual abuse.

The PREA final report for the one allegation that a staff member committed sexual abuse against a resident was for an incident reported to have occurred at another facility. Because of this, there was no need to move the staff member from the youth's unit. The PREA final report indicated that the disposition was unsubstantiated; therefore, the staff member was not indicted or convicted. The facility reported that there were zero residents who had made an allegation of sexual abuse, and during the

random resident interviews none of them said they had made such a report; therefore, there were no interviews with residents who reported a sexual abuse.

115.373 (d)

TJJD policy, GAP 380.9337(k)(3)(C), requires that following a youth's allegation that he or she was sexually abused by another youth, TJJD informs the youth when 1) TJJD learns that the abuser has been indicted on a charge related to sexual abuse, or 2) TJJD learns that the alleged abuser has been convicted on a charge related to sexual abuse.

The PAQ indicated that there were no allegations that a resident had been sexually abused by another resident of Ayres House during the reporting period; therefore, there were no records to review for this provision. The facility reported that there were zero residents who had made an allegation of sexual abuse, and during the random resident interviews none of them said they had made such a report; therefore, there were no interviews with residents who reported a sexual abuse. **115.373 (e)** TJJD policy does not require documentation on all such notifications or attempted notifications under this standard. However, the Superintendent confirmed that all notifications would be documented.

(f): The auditor is not required to audit this provision.

Corrective Action:

1. Develop a procedure that clearly outlines who is responsible for making the notification requirements of §115.373(a) when the alleged incident occurred at a different TJJD facility.
2. Train staff responsible for making the notifications required in §115.373(a) of the procedures outlining who is responsible for making the notification when the alleged incident occurred at a different TJJD facility.
3. The auditor will require documentation of the procedures and evidence of staff training within the first four months of the corrective action period. Once received, the auditor will interview the applicable Ayres House staff.

Verification of Corrective Action since the Interim Audit Report

The auditor gathered, analyzed, and retained the following additional evidence provided by the facility during the corrective action period relevant to the requirements in this standard.

Additional Documentation Reviewed:

- PREA Training Acknowledgement Form and Sign-In Sheet.
- TJJD Sexual Abuse Notification Procedures

Additional Interviews Conducted:

- Superintendent
- Assistant Superintendent/PREA Compliance Manager

The auditor reviewed TJJD Sexual Abuse Notification Procedures provided by the PREA Coordinator during the Corrective Action Period. The procedures specifically state that it is the duty of the Superintendent or designee "at the TJJD facility where the allegation/complaint was received" to make all notifications required under §115.373 regarding a youth's allegation of sexual abuse at another TJJD facility. The auditor also reviewed a PREA Training Acknowledgement Form and Sign-In Sheet for a

training on November 6, 2018 called Sexual Abuse Notification Procedures. The acknowledgement form was signed by the Superintendent and the Assistant Superintendent, indicating their attendance.

Interviews with the Superintendent and Assistant Superintendent confirmed their knowledge of notification procedures. The facility reported receiving no youth allegations of sexual abuse that occurred at another facility and the interviewed residents did not indicate they had made any reports; therefore, there were no records to review to determine compliance.

Based on a review of the TJJD Sexual Abuse Notification Procedures, the PREA Training Acknowledgement Form and Sign-In Sheet and interviews with the Superintendent and Assistant Superintendent, the auditor finds the facility is in compliance with this standard.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.376 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.376 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.376 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (I)
3. Personnel Policy and Procedure Manual (PRS) 11.19
4. Employee Handbook

115.376 (a)

TJJD policy, GAP 380.9337(I)(1)(A), states that staff members who violate the agency's sexual abuse or sexual harassment policies are subject to disciplinary sanctions up to and including termination.

115.376 (b)

TJJD policy, GAP 380.9337(I)(1)(B), states that termination of employment is the presumptive disciplinary sanction for staff members who have engaged in sexual abuse.

The auditors reviewed the *Employee Handbook* which classifies sexual abuse with a youth involved in the juvenile justice system as a violation level 4 (page 18), with a disciplinary sanction of termination (page 14). Engaging in intimate verbal or written communication with a youth and providing or exchanging pictures or other materials of a sexual nature with a youth are also classified as a violation level 4.

The PAQ was answered to indicate that there were no staff from the facility that have violated agency sexual abuse or sexual harassment policies. Additionally, the auditors' interviews with residents and staff and review of documentation did not identify any staff that had violated agency sexual abuse or harassment policies; therefore, there were no records to review regarding terminations, resignations, or other sanctions for violation or sexual abuse or harassment policies.

115.376 (c)

TJJD policy, GAP 380.9337 (I)(1)(C), states that disciplinary sanctions will be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

The PAQ was answered to indicate that there were no staff from the facility that have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies. Additionally, the auditors' interviews with residents and staff and review of documentation did not identify any staff that have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies; therefore, there were no records to review for this provision.

The facility reports zero instances of staff members being reported to law enforcement or licensing bodies following a termination or resignation prior to termination. Additionally, the auditors' interviews with residents and staff and review of documentation did not identify any staff members who were reported to law enforcement or licensing bodies following a termination or resignation prior to termination; therefore, there were no records to review regarding disciplinary sanctions taken against staff for violations of the agency sexual abuse or sexual harassment policies in the past 12 months.

115.376 (d)

TJJD policy, GAP 380.9337 (I)(1)(D), requires reporting the following actions to relevant licensing bodies 1) terminations of employment for violations of TJJD sexual abuse or sexual harassment policies, and 2) resignations by staff members who would have been terminated if they had not resigned.

The PAQ was answered to indicate that there were no staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies. Additionally, the auditors' interviews with residents and staff and review of documentation did not identify any staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies; therefore, there were no records of reports to law enforcement for violations of agency sexual abuse or sexual harassment policy to review.

Conclusion:

Based on review of agency policy and the Employee Handbook, the auditor finds the agency in compliance with this provision.

Standard 115.377: Corrective action for contractors and volunteers**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report****115.377 (a)**

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.377 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337(l)(2)
3. Memorandum from the PREA Compliance Manager documenting zero allegations or reprimands

Interviews:

1. Superintendent

115.377 (a)

TJJD policy, GAP 380.9337 (l)(2)(A), states:

(A) If a contractor or volunteer engages in sexual abuse, TJJD:

- (i) prohibits the contractor or volunteer from having any contact with TJJD youth and
- (ii) reports the finding of abuse to any relevant licensing bodies.

The PAQ was answered to indicate that in the last 12 months, zero contractors/volunteers have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents. Additionally, the facility provided a memo signed by the PREA Compliance Manager stating that Ayres House had no volunteer services postponed or terminated for violations of PREA related allegations/investigation since January 2017. The auditors found no information to contradict this through document review and resident and staff interviews; therefore, there was no relevant documentation to review for this provision.

115.377 (b)

TJJD policy, GAP 380.9337 (l)(2)(B) states that if a volunteer or contractor violates TJJD sexual abuse or sexual harassment policy, but does not actually engage in sexual abuse, TJJD will take appropriate remedial measures and consider whether to prohibit further contact with TJJD youth. During her interview, the Superintendent confirmed this practice.

Conclusion:

Based on review of agency policy, the memo from the PREA Compliance Manager, and the interview with the Superintendent, the auditor has determined that the facility is in compliance with this standard.

Standard 115.378: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?
☒ Yes ☐ No

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No
- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No
- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.378 (g)

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)
☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (I)
3. GAP 380.9503(i)(21)
4. Memorandum from Superintendent documenting zero disciplinary actions for youth alleging abuse

Interviews:

1. Superintendent

115.378 (a)

TJJD policy, GAP 380.9337(I)(3)(A) states that a youth may be subject to disciplinary sanctions for engaging in sexual abuse when there is a criminal finding of guilt or an administrative finding that the youth engaged in youth-on-youth sexual abuse and the discipline is determined through a Level II due process hearing.

The facility answered the PAQ to indicate that there have been two administrative findings of resident-on-resident sexual abuse that have occurred at the facility. The facility provided documentation related to a single incident involving a consensual sexual encounter between two residents that was a violation of the Texas Penal Code, but did not meet the PREA definition of sexual abuse. The reviewed documentation was a request to revoke the residents' parole status, for a violation of a condition of parole, and place them in a secure TJJD facility. The criminal investigation related to this case is still pending.

Through review of the supplied documentation and consideration of the fact that no residents said they had reported an instance of sexual abuse, the auditor determined that there were zero administrative or criminal findings regarding youth-on-youth sexual abuse occurring in the facility in the past 12 months. There was no applicable documentation to review for this provision.

115.378 (b)

TJJD policy, GAP 380.9337(I)(3)(B), states that any disciplinary sanctions must be commensurate with the nature and circumstances of the abuse committed, the youth's disciplinary history, and the sanctions imposed for comparable offenses by other youth with similar histories. Additionally, GAP 380.9337(I)(3)(D) states that TJJD does not impose isolation as a disciplinary sanction.

The PAQ was answered to indicate that zero residents have been placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse.

In her interview, the Superintendent confirmed that sanctions comply with the requirements of this provision. She also stated that isolation is not used at Ayres House. During the site review, it was noted that there are no rooms set up to be used as isolation cells. There was no applicable documentation to review for this provision.

115.378 (c)

TJJD policy, GAP 380.9337(I)(3)(C), states that the disciplinary process must consider whether a youth's mental disability or mental illness contributed to his or her behavior.

During her interview the Superintendent confirmed that they have to consider a resident's mental illness or mental disability in the disciplinary process.

Through review of the supplied documentation and consideration of the fact that no residents said they had reported an instance of sexual abuse, the auditor determined that there were zero administrative or criminal findings regarding youth-on-youth sexual abuse occurring in the facility in the past 12 months. There was no applicable documentation to review for this provision.

115.378 (d)

TJJD policy, GAP 380.9337(I)(3)(E), requires that the facility offer counseling and other interventions designed to address and correct underlying reasons or motivations for the abuse and says that TJJD may require participation as a condition of access to behavior-based incentives, but not as a condition to access general programming or education.

The interviewed mental health staff confirmed that the facility would consider whether to offer the offending resident participation in interventions, such as the Sexual Behavior Treatment Program. She said that participation is not required as a condition of access to programming or education.

Through review of the supplied documentation and consideration of the fact that no residents said they had reported an instance of sexual abuse, the auditor determined that there were zero administrative or criminal findings regarding youth-on-youth sexual abuse occurring in the facility in the past 12 months. There was no applicable documentation to review for this provision.

115.378 (e)

TJJD policy, GAP 380.9337(I)(3)(F) states that a youth may be disciplined for sexual contact with staff only upon a finding that the staff did not consent to such contact. There was no applicable documentation to review for this provision.

Through review of the supplied documentation and consideration of the fact that no residents said they had reported an instance of sexual abuse, the auditor determined that there were zero administrative or criminal findings regarding youth-on-youth sexual abuse occurring in the facility in the past 12 months. There was no applicable documentation to review for this provision.

115.378 (f)

TJJD policy, GAP 380.9337(I)(3)(G) states that a youth may not be disciplined if the youth made a report of sexual abuse in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

115.378 (g)

TJJD policy, GAP 380.9503(i)(21), prohibits all sexual activity between youth. GAP 380.9337 (I)(3)(H) states that TJJD may discipline a youth for engaging in prohibited sexual activity that does not meet the definition of abuse.

Conclusion:

Based on review of agency policy, the memorandum from PREA Compliance Manager documenting zero disciplinary actions for youth alleging abuse, and the interviews with the Superintendent and mental health staff, the auditor finds the agency in compliance with this standard.

MEDICAL AND MENTAL CARE

Standard 115.381: Medical and mental health screenings; history of sexual abuse

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (m)

Interviews:

1. Staff responsible for risk screening
2. Medical and mental health staff

115.381 (a)

TJJD policy, GAP 380.9337(m)(1)(A) states that regardless of the intake screening results, TJJD offers all youth an appointment with a medical and mental health practitioner within 14 days after the intake screening.

The facility answered the PAQ to indicate that all residents who disclose prior sexual victimization during a screening are offered a follow up meeting with a medical or mental health practitioner, but that there were no residents who disclosed prior victimization during screening. The initial screening occurs at the Ron Jackson Orientation Unit and most residents would have disclosed prior victimization at that time. During the interview with the staff responsible for risk screening, she indicated that if the resident disclosed prior victimization during a screening at Ayres House, a follow up meeting would be scheduled immediately.

The auditors reviewed the medical and mental health records for seven residents. The records for one of the reviewed residents indicated prior sexual victimization that was disclosed during the intake

screen at the Ron Jackson Orientation Unit. All seven residents, including the one with prior sexual victimization, had an initial mental health screening the day they arrived at the Ron Jackson orientation unit and a follow up psychological evaluation within 14 days.

115.381 (b)

TJJD policy, GAP 380.9337(m)(1)(A), states that regardless of the intake screening results, TJJD offers all youth an appointment with a medical and mental health practitioner within 14 days after the intake screening.

The facility answered the PAQ to indicate that all residents who have previously perpetrated sexual abuse as indicated during the screening are offered a follow-up meeting with a mental health practitioner, but that there were no residents who disclosed that they have previously perpetrated sexual abuse during their screening. The initial screening occurs at the Ron Jackson Orientation Unit and most residents would have disclosed that they have previously perpetrated sexual abuse at that time. During the interview with the staff responsible for risk screening, she indicated that if the resident disclosed that they have previously perpetrated sexual abuse during a screening at Ayres House, a follow up meeting would be scheduled immediately.

The auditors reviewed the medical and mental health records for seven residents. All seven residents had an initial mental health screening they day they arrived at the Ron Jackson orientation unit and a follow up psychological evaluation within 14 days.

115.381 (c)

TJJD policy, GAP 380.9337(m)(1)(B), states that any information obtained related to sexual victimization or abusiveness that occurred in an institutional setting must be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by law.

Youth medical information is stored electronically in the Electronic Medical Records system which is administered through the University of Texas Medical Branch. Access to this database is protected with dual logins required to gain access. Ayres House does not have an infirmary, only a med-room used to store and dispense medications. The auditors noted no medical record storage anywhere in the facility.

115.381 (d)

TJJD policy, GAP 380.9337(m)(1)(B), states that medical and mental health practitioners must obtain informed consent from youth before reporting information about prior sexual victimization that that did not occur in an institutional setting, unless the youth is under the age of 18.

During interviews with medical and mental health staff, they indicated that they obtain informed consent if the resident is 18, but that residents under the age of 18 are told that they have to report prior sexual victimization.

Conclusion:

Based on review of agency policy, and interviews with medical and mental health staff and the staff responsible for risk screening, the auditor finds the agency in compliance with this standard.

Standard 115.382: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? ☒ Yes ☐ No

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No
- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.382 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (m)

Interviews:

1. Medical and mental health care staff
2. Staff first responders

115.382 (a)

TJJD policy, GAP 380.9337(m)(2)(A), states that youth victims of sexual abuse shall receive timely unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners per their professional judgment.

Youth at Ayres House receive routine medical care at the Giddings State School secure facility in Giddings, TX. The Superintendent indicated that if a sexual abuse event occurred at Ayres House, staff would contact medical staff at Giddings State School to determine what hospital to take the victim to for emergency medical treatment.

Interviews with medical and mental health staff at Giddings State School confirmed that the victim would receive immediate access to emergency medical treatment. The nature and scope of emergency treatment would be determined by the SAFE/SANE staff at the hospital. Mental health staff indicated that crisis intervention services would be provided to the victim by a qualified TJJD staff member who would determine the nature and scope of services required.

The facility reported no incidents of resident sexual abuse requiring emergency medical treatment and crisis intervention services. Additionally, the auditors' interviews with staff and residents and review of documentation did not disclose any cases of resident sexual abuse that would require emergency medical treatment and crisis intervention services; therefore, there were no medical/mental health secondary materials to review or interviews with residents who reported a sexual abuse.

115.382 (b)

TJJD policy, GAP 380.9337(m)(2)(B), states that if no qualified medical or mental health practitioners are on duty at the time of a report of recent abuse is made, staff first responders must take preliminary steps to protect the victim and must immediately notify the appropriate medical and mental health practitioners.

Interviews with staff first responders indicated knowledge of the first responder protocols and that they would take steps pursuant to §115.362, including notifying medical and mental health staff.

The facility reported no incidents of resident sexual abuse requiring emergency medical treatment and crisis intervention services. Additionally, the auditors' interviews with staff and residents and review of documentation did not disclose any cases of resident sexual abuse that would require emergency medical treatment and crisis intervention services; therefore, there was no documentation to review for this provision.

115.382 (c)

TJJD policy, GAP 380.9337(m)(2)(C), requires that TJJD offers youth victims of sexual abuse timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, and where medically appropriate.

Interviews with medical staff confirm that this would occur at the local hospital where the youth would be transported for the SANE or SAFE exam. The facility reported no incidents of resident sexual abuse requiring emergency medical treatment and crisis intervention services. Additionally, the auditors' interviews with staff and residents and review of documentation did not disclose any cases of resident sexual abuse that would require emergency medical treatment and crisis intervention services; therefore, there were no medical/mental health secondary materials to review.

115.382 (d)

TJJD policy, GAP 380.9337(m)(2)(D), requires that the agency offer these treatment services to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident.

Interviews with medical and mental health staff corroborated that victims are not charged for these treatment services.

The facility reported no incidents of resident sexual abuse requiring emergency medical treatment and crisis intervention services. Additionally, the auditors' interviews with staff and residents and review of documentation did not disclose any cases of resident sexual abuse that would require emergency medical treatment and crisis intervention services; therefore, there documentation to review for this provision.

Conclusion:

Based on review of agency policy, and interviews with medical and mental health staff and staff first responders, the auditor finds the agency in compliance with this standard.

Standard 115.383: Ongoing medical and mental health care for sexual abuse victims and abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (m)

Interviews:

1. Medical and mental health care staff

115.383 (a)

TJJD policy, GAP 380.9337(m)(3)(A), states that TJJD offers medical and mental health evaluations and, as appropriate, treatment to all youth who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

Interviews with medical and mental health staff at the Giddings facility indicated that all youth undergo a screening during intake and periodically throughout their stay and receive follow-up services as needed.

115.383 (b)

TJJD policy, GAP 380.9337(m)(3)(A)(i), requires that the evaluation and treatment of victims include follow-up services, treatment plans, and referrals for continued care following a youth's transfer to other facilities or release from custody.

Mental health care staff said a risk assessment is conducted to see if the victim is in distress and counseling and therapy are offered.

Medical records were reviewed for the one resident who made an allegation at Ayres House of sexual abuse that occurred at another TJJD facility. That resident absconded from Ayres House nine days after making his report; therefore, there were no follow up services, treatment plans or referrals for continued care to review. Interviews with staff and residents and review of documentation did not disclose any additional cases of resident sexual abuse that would require follow up services; therefore, there were no medical records or secondary documentation to review.

115.383 (c)

TJJD policy, GAP 380.9337(m)(3)(A)(ii), states that TJJD provides such victims with medical and mental health services consistent with the community level of care.

During interviews, medical and mental health care staff reported the level of care provided is consistent with the community level of care.

Medical records were reviewed for the one resident who made an allegation at Ayres House of sexual abuse that occurred at another TJJD facility. That resident absconded from Ayres House nine days after making his report; therefore, there were no follow up services, treatment plans or referrals for continued care to review. Interviews with staff and residents and review of documentation did not disclose any additional cases of resident sexual abuse that would require follow up services; therefore, there were no medical records or secondary documentation to review for this provision.

115.383 (d)

Ayres House is an all-male facility; therefore, this provision is not applicable.

115.383 (e)

Ayres House is an all-male facility; therefore, this provision is not applicable.

115.383 (f)

TJJD policy, GAP 380.9337(m)(3)(C), states that TJJD ensures tests for sexually transmitted infections are offered, as medically appropriate, to youth victims of sexual abuse while incarcerated.

The sexual abuse reported by the resident of Ayres House that occurred at another TJJD facility was not of a nature that would require tests for sexually transmitted infections. Additionally, that resident had absconded and was not able to be interviewed. Interviews with staff and residents and review of documentation did not disclose any additional cases of resident sexual abuse that would require tests for sexually transmitted infections; therefore, there were no medical records or secondary documentation to review for this provision.

115.383 (g)

TJJD policy, GAP 380.9337(m)(3)(D), states that all treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

The sexual abuse reported by the resident of Ayres House that occurred at another TJJD facility was not of a nature that would require additional treatment services. Additionally, that resident had absconded and was not able to be interviewed. Interviews with staff and residents and review of documentation did not disclose any additional cases of resident sexual abuse that would require tests for sexually transmitted infections; therefore, there were no interviews with residents who reported a sexual abuse.

115.383 (h)

TJJD policy, GAP 380.9337(m)(3)(E), states that TJJD attempts to conduct a mental health evaluation of all known youth-on-youth abusers within 60 days of learning of such abuse history and shall offer treatment when deemed appropriate by mental health care staff.

Mental health staff reported that a youth-on-youth abuser would receive a risk-assessment immediately upon learning of such history and would be offered treatment.

The facility reported no resident-on-resident abusers. Additionally, interviews with staff and residents and review of documentation did not disclose any resident-on-resident abusers; therefore, there were no medical records or secondary documentation to review.

Conclusion:

Based on review of agency policy, and interviews with medical and mental health staff and staff first responders, the auditor finds the agency in compliance with this standard

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No

- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (n)
3. Sexual Abuse Incident Review Board (SARB) Report
4. Memo from the Superintendent regarding members of the SARB

Interviews:

1. Facility Superintendent
2. PREA Compliance Director
3. Incident review team member

115.386 (a)

TJJD policy, GAP 380.9337(n)(1), states that TJJD conducts an incident review at the conclusion of every sexual abuse investigation unless the allegation is determined to be unfounded.

The facility reported one criminal investigation of alleged sexual abuse that was not “unfounded.” This incident was alleged to have occurred at a different TJJD facility; therefore, an incident review was not conducted at Ayres House. The facility provided for review *Sexual Abuse Incident Review Board (SARB) Reports* for four SARB meetings held at Ayres House for incidents of sexual misconduct that did not meet the PREA definition of sexual abuse.

115.386 (b)

The PAQ was answered to indicate that sexual abuse incident reviews are ordinarily conducted within 30 days of concluding the criminal or administrative investigation. The four reviewed SARB meetings were all conducted within 30 days of the conclusion of the criminal investigation.

115.386 (c)

TJJD policy, GAP 380.9337(n)(2) requires that managers, supervisors, investigators, and medical or mental health practitioners participate in the review.

The PREA Compliance Manager provided a memo with the names of the individuals making up the SARB, consisting of the Superintendent, Assistant Superintendent, JCO Supervisors, two medical/mental health professionals and investigators. The reviewed documentation reflected consistent participation in the SARB meetings by the Superintendent, medical/mental health practitioners, JCO Supervisors and investigative staff.

115.386 (d)

TJJD policy, GAP 380.9337(n)(3) states:

(3) The review team:

- (A) considers whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
- (B) considers whether the incident or allegation was motivated by race; ethnicity; gender identity; status or perceived status as lesbian, gay, bisexual, transgender, or intersex; gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;
- (C) examines the area where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
- (D) assesses the adequacy of staffing levels in that area during different shifts;
- (E) assesses whether monitoring technology should be used or enhanced to supplement supervision by staff; and
- (F) submits a report of its findings and recommendations to the facility administrator, the local PREA compliance manager, and other appropriate staff members.

The *Sexual Abuse Incident Review Board (SARB) Report* was reviewed by the auditors. It includes discussion topics addressing each of the elements for this provision above, and also includes minutes, names of members present/absent, statement of finding, recommendations, and action plan. The reviewed documentation of the SARB meetings contained all information required on the form. Each section was completed with full explanations of the review boards reasoning.

The Superintendent confirmed that the review team considers all factors required in this provision. She said that the information from the SARB meetings is used to consider if something could have been prevented and recommendations might include staffing and supervision changes, camera placement changes, changes to a resident's medical and mental health plan, and training. The PREA Compliance Manager confirmed that the facility conducts sexual abuse incident reviews and prepares a report of its findings and recommendations. He is a part of the SARB and he reviews all reports and has not seen any trends yet. He said that the data for Ayres House is used by the agency to compare incidents at all TJJD facilities and look for trends and changes that might need to be made at the facility and agency-wide. The interviewed staff member from the incident review team said that everything is considered in the review. He said they consider the individuals involved in the incident and look at different aspects and points of view that might be motivating factors. He said they examine all areas of the facility in which the incident occurred and are aware of the most vulnerable areas of the facility. He said they consider staffing levels and try to have extra staff on each shift when possible. Cameras are monitored daily and camera placement is discussed during the incident review.

115.386 (e)

TJJD policy, GAP 380.9337(n)(4), requires that the facility implement the SARB's recommendations or document the reasons for not doing so. In each of the four reviewed SARB meetings, the facility appeared to have followed through on the recommendations. Actions included placing youth on a safety plan, assigning residents to different rooms, and submitting a work order to change camera realignment for a better view.

Conclusion:

Based on review of agency policy, review of Sexual Abuse Incident Review Board (SARB) Reports, and interviews with the Superintendent, PREA Compliance Manager, and a staff member on the incident review team, the auditor finds the facility in compliance with this standard.

Standard 115.387: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually?
☒ Yes ☐ No

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?
☒ Yes ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☒ Yes ☐ No ☐ NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)
☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (o)
3. PREA Data Collection System
4. Documentation of approval by the TJJD Executive Director'
5. TJJD website

6. PREA Annual Reports

Interviews:

1. Superintendent
2. Interim PREA Coordinator

115.387 (a) and (c)

TJJD policy, GAP 380.9337 (o)(1-2), states,

- (1) TJJD collects data for every allegation of sexual abuse at TJJD-operated facilities using a standardized instrument and set of definitions and aggregates the data at least once each year. TJJD also maintains, reviews, and collects data as needed from all available incident-based documents, such as reports, investigation files, and sexual abuse incident reviews.
- (2) TJJD develops its data collection instrument to include the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the U.S. Department of Justice.

The agency provided screenshots of their data collection system for review and it contained the data necessary to answer the questions from the Survey of Sexual Violence.

According to the PREA Coordinator, AID and OIG investigations marked as PREA related populate a PREA Data Collection System. The PREA Data Collection System pulls data from TJJD's database with youth records to include additional information, such as a resident's age and gender. The Interim PREA Coordinator will review each investigation and classify it according to the definitions in §115.6

115.387 (b)

TJJD policy, GAP 380.9337 (o)(1), requires that TJJD aggregate the data at least once each year. The interview with the PREA Coordinator corroborated that the data is collected once per year.

TJJD's website was reviewed and yearly PREA Annual Reports were available for each year from 2014-2016 containing aggregated data.

115.387 (d)

TJJD policy, GAP 380.9337 (o)(1) requires that TJJD maintain, review, and collect data as needed from all available incident-based documents, such as reports, investigation files, and sexual abuse incident reviews.

The Interim PREA Coordinator confirmed that the agency maintains, reviews and collects data from these sources as needed. She said this information is reviewed each year when preparing the PREA Annual Report.

115.387 (e)

TJJD policy, GAP 380.9337 (o)(3), requires that TJJD obtain incident-based and aggregate data from each residential facility operating under a contract with TJJD.

The auditors reviewed the provided information from the PREA Data Collection System to ensure the data is aggregated by each facility.

During her interview, the Interim PREA Coordinator confirmed that contract facilities are included in the data collection. The most recent PREA Annual Report (2016) was reviewed and it stated that collected data included sexual abuse at state operated and contracted facilities.

115.387 (f)

The PAQ was answered to indicate that the agency provided the Department of Justice with data from the previous calendar year upon request.

A review of TJJD's website found a Survey of Sexual Victimization completed for the years 2015 and 2016, indicating that this information is provided as requested.

Conclusion:

Based on review of agency policy, the PREA Data Collection System, agency PREA Annual Reports, completed Surveys of Sexual Victimization, the agency website and the interview with the Interim PREA Coordinator, the auditor finds the agency in compliance.

Standard 115.388: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No
- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No
- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (p)
3. PREA Annual Reports

Interviews:

1. Interim PREA Coordinator
2. PREA Compliance Manager
3. Executive Director

115.388 (a)

TJJD policy, GAP 380.9337 (o)(1), requires that TJJD review aggregate sexual abuse data to assess and improve the effectiveness of its policies, practices, and training. Following this review, TJJD prepares an annual report of its findings and corrective actions for each facility and the agency as a whole.

The Executive Director confirmed her knowledge of the data review and said that the incident-based sexual abuse data is used to collectively look at trends to see if the agency can do better. The Interim PREA Coordinator said that each facility prepares an annual corrective action plan based on the allegations explaining what actions they will take to further prevent, detect, and respond to allegations of sexual abuse and harassment. The PREA Compliance Manager said that the action plan for Ayres

House is compared to those of other TJJD facilities to look for trends and changes that might need to be made at the facility and agency-wide.

115.388 (b)

TJJD Policy, GAP 380.9337(p)(1) states that, "TJJD reviews aggregate sexual abuse data to assess and improve the effectiveness of its policies, practices, and training. Following this review, TJJD prepares an annual report of its findings and corrective actions for each facility and the agency as a whole. The report will be posted on the agency's website."

The auditor reviewed the 2016 Annual Report to ensure the review included a comparison of the previous year's sexual abuse data. The report compares the years 2014, 2015 and 2016. The Annual Report includes aggregated data for TJJD facilities and contract facilities, and agency-wide current and future plans, corrective actions, and proactive steps taken to eliminate sexual abuse and harassment.

115.388 (c)

TJJD policy, GAP 380.9337(p)(2), requires that TJJD post on its website all aggregated sexual abuse data from TJJD-operated and contracted facilities. Although policy does not require the agency head to approve the report, the Executive Director confirmed during her interview that she does approve it.

The TJJD website was reviewed and PREA Annual Reports were available for each year from 2014-2016.

115.388 (d)

The interview with the Interim PREA Coordinator indicated that no information is has ever been redacted from the annual report. She confirmed that if information should ever be redacted from the report, the agency would indicate the nature of the material redacted.

The annual reports for 2014-2016 were reviewed and it appears that no information was redacted.

Conclusion:

Based on review of agency policy, agency PREA Annual Reports, the agency website and the interview with the Interim PREA Coordinator, PREA Compliance Manager, and the Executive Director, the auditor finds the agency in compliance.

Standard 115.389: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained?
☒ Yes ☐ No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (o), (p)
3. TJJD website

Interviews:

1. Interim PREA Coordinator

115.389 (a)

TJJD policy, GAP 380.9337(o)(4), requires that TJJD securely retain all sexual abuse data.

The Interim PREA Coordinator said that the data is password protected and only the PREA Coordinator has access to the database. The data is derived from the OIG and AID databases and access to these is strictly limited. She said that the agency takes corrective action on an ongoing basis if the data reveals action is needed.

115.389 (b)

TJJD policy, GAP 380.9337(p)(2), requires that TJJD post on its website all aggregated sexual abuse data from TJJD-operated and contracted facilities.

The TJJD website was reviewed and PREA Annual Reports were available for each year from 2014-2016.

115.389 (c)

A review of the PREA Annual Reports published on the agency website found no personal identifiers.

115.389 (d)

The record retention schedule for OIG criminal investigation files was provided. The schedule requires that criminal investigation files pertaining to PREA that involve a youth suspect be kept for 20 years after the case is closed and criminal investigation files pertaining to PREA that involve an employee suspect be kept for 50 years after the case is closed. This meets the requirement of the provision.

Conclusion:

Based on review of agency policy, OIG record retention schedule, and the TJJD website and the interview with the Interim PREA Coordinator, the auditor finds the agency in compliance with this standard.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*) ☐ Yes ☒ No
- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the second year of the current audit cycle.) ☒ Yes ☐ No ☐ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.401 (a)

Audits were conducted for all TJJD operated facilities during the prior three-year audit period. There are no facilities operated by a private organization on behalf of the agency.

115.401 (b)

This is the second year of the current audit cycle. During the first year of the cycle, PREA audits were conducted for four of the 13 TJJD operated facilities.

115.401 (h)

The auditors were provided full access to, and the ability to observe, all areas of the audited facility.

115.401 (i)

The audit team was permitted to request and receive copies of any relevant documents.

115.401 (m)

The auditors were allowed to private interviews with residents.

115.401 (n)

The lead auditor did not receive any correspondence as a result of the posted PREA audit notices. It was noted during the On-site audit that residents are able to send mail in the same manner as if they were communicating with legal counsel.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.403 (f)

The auditor reviewed the agency's website and all prior PREA audits for the past three years are posted.

AUDITOR CERTIFICATION

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☒ I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.¹ Auditors are not permitted to submit audit reports that have been scanned.² See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Emily Childs

February 26, 2019

Auditor Signature

Date

¹ See additional instructions here: <https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110>.

² See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.